



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
American Samoa**

**Application for 2011
Annual Report for 2009**



Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	5
C. Needs Assessment Summary	5
III. State Overview	7
A. Overview.....	7
B. Agency Capacity.....	10
C. Organizational Structure.....	10
D. Other MCH Capacity	11
E. State Agency Coordination.....	13
F. Health Systems Capacity Indicators	16
Health Systems Capacity Indicator 01:	17
Health Systems Capacity Indicator 02:	17
Health Systems Capacity Indicator 03:	18
Health Systems Capacity Indicator 04:	19
Health Systems Capacity Indicator 07A:	20
Health Systems Capacity Indicator 07B:	20
Health Systems Capacity Indicator 08:	21
Health Systems Capacity Indicator 05A:	21
Health Systems Capacity Indicator 05B:	22
Health Systems Capacity Indicator 05C:	22
Health Systems Capacity Indicator 05D:	23
Health Systems Capacity Indicator 06A:	23
Health Systems Capacity Indicator 06B:	24
Health Systems Capacity Indicator 06C:	24
Health Systems Capacity Indicator 09A:	25
Health Systems Capacity Indicator 09B:	25
IV. Priorities, Performance and Program Activities	27
A. Background and Overview	27
B. State Priorities	27
C. National Performance Measures.....	27
Performance Measure 01:	27
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated	28
Performance Measure 02:	29
Performance Measure 03:	32
Performance Measure 04:	34
Performance Measure 05:	36
Performance Measure 06:	38
Performance Measure 07:	40
Performance Measure 08:	43
Performance Measure 09:	45
Performance Measure 10:	47
Performance Measure 11:	49
Performance Measure 12:	52
Performance Measure 13:	53
Performance Measure 14:	55
Performance Measure 15:	57
Performance Measure 16:	59

Performance Measure 17:.....	60
Performance Measure 18:.....	62
D. State Performance Measures.....	64
State Performance Measure 1:	64
State Performance Measure 2:	67
State Performance Measure 3:	68
State Performance Measure 4:	70
State Performance Measure 5:	72
State Performance Measure 6:	73
State Performance Measure 7:	75
E. Health Status Indicators	77
Health Status Indicators 01A:.....	77
Health Status Indicators 01B:.....	77
Health Status Indicators 02A:.....	78
Health Status Indicators 02B:.....	78
Health Status Indicators 03A:.....	79
Health Status Indicators 03B:.....	79
Health Status Indicators 03C:.....	80
Health Status Indicators 04A:.....	80
Health Status Indicators 04B:.....	81
Health Status Indicators 04C:.....	81
Health Status Indicators 05A:.....	82
Health Status Indicators 05B:.....	82
Health Status Indicators 06A:.....	83
Health Status Indicators 06B:.....	83
Health Status Indicators 07A:.....	84
Health Status Indicators 07B:.....	84
Health Status Indicators 08A:.....	85
Health Status Indicators 08B:.....	85
Health Status Indicators 09A:.....	86
Health Status Indicators 09B:.....	86
Health Status Indicators 10:	87
Health Status Indicators 11:	87
Health Status Indicators 12:	88
F. Other Program Activities.....	88
G. Technical Assistance	89
V. Budget Narrative	90
Form 3, State MCH Funding Profile	90
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	90
Form 5, State Title V Program Budget and Expenditures by Types of Services (II)	91
A. Expenditures.....	91
B. Budget	91
VI. Reporting Forms-General Information	93
VII. Performance and Outcome Measure Detail Sheets	93
VIII. Glossary	93
IX. Technical Note	93
X. Appendices and State Supporting documents.....	93
A. Needs Assessment.....	93
B. All Reporting Forms.....	93
C. Organizational Charts and All Other State Supporting Documents	93
D. Annual Report Data	93

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the MCH office.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2011/

Following the Needs Assessment process, the MCH Program engaged a multidisciplinary group of partners and stakeholders to participate. These partners included health and medical professionals as well as community based organizations. This larger body was further divided into three work groups based on the three MCH populations. Upon completion of the Needs Assessment this work group was reconvened to develop the plan for the coming year.

Each of the three work groups (Children and Adolescents, Pregnant Women and Infants, and Children with Special Health Care Needs) worked collaboratively on the Needs Assessment, and the application for the 2011 fiscal year. Each Performance Measure and activity was reviewed in small groups as well as collectively as a whole in a working meeting convened for this purpose. Each group reviewed the portions of the work plan specific to their population group prior to the larger work session to enable time for input into the process.

Changes, feedback and additions to the work plans were added during this working session. Some of the work group members who were not present at this meeting were contacted individually in order to include their feedback into this submission.

The MCH Program has every confidence this work plan was developed as a collaborative effort with its partners and key stakeholders. The activities documented herein will be implemented collaboratively with these partners as well.

//2011//

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

A strength of the needs assessment process was the involvement and wide participation by all of the MCH staff and representatives from the other agencies and programs that provide services to the MCH population. However, there were also many challenges. The most significant weaknesses were the lack of an MCH Epidemiologist to coordinate the tasks and the lack of consistent data in a format that was usable and the lack of current population data. Therefore, we recognize that the results for the data indicators may differ from year to year and makes trend analysis difficult if not impossible. However, limited, the needs assessment presents the most recent and the best available data from these resources.

Health Status and Needs -- Pregnant women, mothers, infants: The quantitative data for this MCH population included analysis of the birth trends, Kotelchuck Index that measures the adequacy of prenatal care utilization, initiation of prenatal care, teen births, and the infant mortality rate. Qualitative assessment included data from focus groups of women who delivered a liveborn and did not receive prenatal care during the pregnancy.

Birth trends have been declining since the year 2000 when there were 30.0 births/1000 population with a gradual and steady decline until 2006 when the birth rate measured 21.6/1000 population. Initiation and utilization of prenatal care continues to be a problem. Data for a sample of 670 women who delivered a live birth, 21.9% initiated care in the first trimester, 51.5% in the second trimester, and 23.1% in the third trimester. In assessing adequacy of utilization of prenatal care, the data showed that 21.6% had an "adequate plus" Kotelchuk Index, 19.1% were "adequate", 8.8% were "intermediate" and 50.4% were "inadequate". The data for teen births for 2009 showed that 9.8% of all births were to mothers ages 15 through 19 years. During 2005 to 2009, the infant mortality rate fluctuated from the lowest of 8.5/1000 live births in 2007 to the highest of 11.6/1000 live births in 2009.

With half of the pregnant women with inadequate utilization of prenatal care services and over half initiating care after the first trimester, there is a need to pursue changes in the policies on how prenatal care clinics operate and charge for services. Some of the recommendations are to include more of the services as a "package" at the prenatal clinics and to charge less for visits and laboratory tests.

Children and youth: The quantitative data for this MCH population included an analysis of the data for immunization, child obesity, dental cavities, morbidity, and youth risk behaviors.

Immunization services are provided by the MCH Program in partnership with the community health centers and the outpatient department of the LBJ Tropical Medical Center. Of major concern is the fact that in 2005, 75.1% of the children were fully immunized and the rate has declined to 56.0% in 2009. Childhood obesity is becoming a major problem as evidenced by data from the well baby clinics and the public schools.

The MCH Dental Program provides dental sealants and evaluation for 3rd grade children (7-9 years) in American Samoa. Data on the caries rates among the 540 children evaluated showed that 69.4% of the children had dental caries in at least one tooth and the data for caries rates for deciduous and permanent teeth showed that 64.1% of the children had caries in at least one deciduous tooth and 25.4% had caries in at least one permanent tooth.

Child morbidity was assessed as admissions to the LBJ Medical Center during 2009. There were 560 admissions of children 5 years and under and of these children, 50.2% were admitted for respiratory tract diseases, 11.6% for infections, and 10.7% for gastrointestinal diseases. When the diagnostic conditions were examined for each age group from 0 to 4 years, admissions for

respiratory diagnoses decreased with age and for infections and injury, admissions increased with age.

There are needs to: (1) Address obesity among children and youth with a comprehensive Territory-wide prevention and intervention program to prevent the secondary complications of chronic diseases associated obesity. (2) Expand the immunization program in the well baby clinics through awareness and education on the importance of immunizations. (3) Develop a comprehensive oral health program to include an educational program for the prevention of dental caries, fluoride supplements supplied through the well baby clinics and well child clinics, and improvement in the rates of dental screening and dental referrals for treatment. (4) Develop and implement a comprehensive nutrition education program in the well baby clinics that reinforce breastfeeding, proper nutrition with feeding of iron-rich foods, and preventing obesity. (5) Develop awareness and education programs for reducing behaviors among youth that lead to injury and violence, a tobacco cessation service targeted for young people, and a comprehensive Territory-wide policy and program to begin to address the problem of overweight and obese children and youths to prevent obesity as this population become adults.

Children with special health needs: The MCH-CSHN Program served 146 children in 2009 of which 43% were diagnosed with cerebral palsy and neurological problems, 17.8% were diagnosed with Down Syndrome, 9.0% with cardiac problems and 7.5% with autism. Other diagnostic categories included cleft palate, developmental delay, seizure disorder, and visual impairments.

There is a need to expand services for children with special needs to include more physical therapy, occupational therapy, nutrition, and medical services; develop a series of training sessions for caregivers on feeding, proper lifting and positioning, and oral hygiene; develop support groups for parents and caregivers to be able to meet; and assure that all youths with special needs are provided with appropriate transition services to meet their needs.

An attachment is included in this section.

III. State Overview

A. Overview

American Samoa is an unincorporated territory of the United States and consists of a group of seven islands in the southern Pacific Ocean located 2,600 miles southeast of Hawai'i and 1,800 miles northeast of New Zealand. The total land area of American Samoa is approximately 76 square miles (200 square km). The main island of Tutuila, the largest island of the group, covers an area of 55 square miles (143 square km) and is home to Pago Pago, the political, administrative, and commercial center of the Territory of American Samoa. Aunu'u Island is one mile off the southeast tip of Tutuila (a 15-minute ferry ride), with a land mass of 0.6 square miles and one village with a population of 476 residents (2000 Census). Sixty miles east of Tutuila is the Manu'a Island group (a 30-minute airplane ride) that includes the volcanic islands of Ofu and Olosega, connected by a bridge, and the Island of Ta'u. These islands are sparsely populated, with a total 2000 Census population of 1,378 residents, and each village having a few hundred residents. The Swains Island is a privately-owned coral atoll located 214 miles north of Tutuila with approximately 1.25 square miles of land mass and a population of 37 residents (2000 Census). Swains Islanders raise coconuts and grow bananas, taro, breadfruit and papaya, and supplement their diet with fish from outside of Swains' reef. Rose Island (coral atoll) lies 78 miles east of Ta'u with a land mass of 0.1 square miles, is uninhabited and is named a national monument.

Based on the American Samoa 2000 Census of Population and Housing (2002), the Territory of American Samoa had a population of 57,291 residents and represents a 22% increase from the 1990 Census of 46,773 residents. Mid-census 2005 population was projected to increase to an estimated 65,500 residents and to 69,200 residents by 2008 and a projected increase to 80,000 by 2010. American Samoa is divided into four geo-political districts: Western District, Eastern District, Manu'a District, and Swains Island District. The population distribution for these districts show that there are 32,435 residents (56.6%) in the Western District, 23,441 residents (40.9%) in the Eastern District, 1,378 (2.4%) in the Manu'a District, and 37 residents (0.06%) in the Swains Island District. Of the total population based on the 2000 Census, there were 29,264 males (51.1%) and 28,027 females (48.9%). In assessing the population distribution by age (Table 1), American Samoa has a relatively young population with over one-third (38.7%) of the population less than 15 years of age. For the total population, the median age stands at 21.3 years with 47.8% of the population less than 20 years of age, 44.1% between 20-59 years, and 8% who are 60 years and above.

Of this total population, 95.8% of the residents reported one ethnicity or race and 4.2% reported two or more races or ethnic groups. Of those who reported one ethnicity, 91.6% reported themselves as Pacific Islanders, 2.8% Asian, 1.1% White, and 0.2% some other race or ethnic group. Of those residents who reported themselves as Pacific Islander, 88.2% are Samoan, 2.8% Tongan, and the remainder are Tokelauan, Fijian, or other Pacific Islander. While the proportion of the American Samoan born population remained above 50%, the foreign-born residents increased from less than 20% in 1960 to over 40% in the 2000 census. The majority of the foreign-born immigrants were from neighboring Samoa with over 30%, the US-born immigrant population was 5 percent.

There are 9,349 households in American Samoa of which 8,706 (93.1%) are family households and 643 non-family households (householder living alone). Of the family households, 6,596 (70.6%) are married-couple families of which 5,261 are households with children under 18 years of age and 1,398 (15%) are female head of household of which 640 have children less than 18 years of age. Of the total households of all types, 7,598 (81.3%) are households with an individual under 18 years of age.

American Samoa has a total land-mass of 70 square miles and an estimated 2008 population of 69,200 residents of which 97.5% reside on the main island of Tutuila the largest island of the

group, that covers an area of 55 square miles (143 square km) and is home to Pago Pago, the political, administrative, and commercial center of the Territory of American Samoa. In addition to the fact that the vast majority of the population of American Samoa is concentrated on one island, the residents of American Samoa are culturally a relatively homogeneous population with a large proportion reporting themselves as Samoan.

Economic Environment

Traditionally the local economy consisted of subsistence farming and fishing. In the 1970's and 1980's the influence of the U.S. mainland standard of living took a significant stronghold in local communities. Since then the concept of subsistence living took a downward trend as young American Samoans left for military services, education and better opportunities on the mainland. Major improvement in the cash economy evidenced by significant increases in exported canned tuna products valuing at over \$400 million annually brought more migrant families from neighboring islands such as Western Samoa and Tonga. Tuna fishing and tuna processing plants are the backbone of the private sector, with canned tuna the primary export. In 1999, the median household income was \$18,219 and the majority (87.8%) of households earned less than \$50,000, while poverty status was determined for more than half (61%) of the population. In 2004, the median household income was \$22,930 and the mean household income was \$32,028. In 2005, a total of 17,344 people were employed that included 6,064 people employed with the government, 4,546 people employed in the tuna canneries, and 6,700 people employed in the private sector. The overall unemployment rate in American Samoa was 29.8%.

The poverty status for American Samoan residents is high based on U.S. standards with a primary factor being the lower minimum wages when compared to the U.S. In 2008, the minimum wage in the U.S. mainland states was \$6.55/hour whereas the minimum wage in American Samoa ranged from \$3.81/hour for government workers to a high of \$4.99/hour for employees in finance and insurance. The other major industries and their minimum wages include construction workers at \$4.60/hour, fish cannery workers at \$4.26/hour, and retail workers at \$4.10/hour. American Samoa has the lowest per capita income in the entire U.S. system including 3141 counties, 50 states and the other U.S. territories.

In examining the 1999 poverty status of residents, 61% of all individuals in American Samoa are considered to be in the poverty status; and of these, 56.6% are individuals above 18 years of age, 47.9% are individuals 65 years and older, 66.5% are children under 18 years of age. When assessing the poverty status of families in American Samoa for the same time period, 58.2% of the families are below the poverty level and of these families 62% are families with related children under 18 years of age and 67.4% are families with children under 5 years of age.

American Samoa is currently participating in the 2010 US Census. The new census information will be included in the MCH program application as it becomes available.

In 2008, the American Samoa Department of Commerce published a report, American Samoa's Economic Future and the Cannery Industry. The study was undertaken to assess American Samoa's economic future especially in view of possible serious reductions in the tuna cannery operations and plant closures because of U.S.-International trade agreements and expanded foreign competition, the loss of federal tax incentives, and the dramatic increase in the minimum wage that took effect in American Samoa 2008. The report states that with the closure of the tuna cannery, there is a strong possibility that economic distress would remain very high in American Samoa for a long time in the form of very high rates of unemployment, business closures or cutbacks and precipitous declines in local revenues. These conditions could have a variety of adverse effects on the community that includes: (1) Increased family and social stress that often translates into criminal behavior including domestic violence. (2) Declining economic opportunities for youth entering the workforce. (3) Declining local revenues for health, education and general public welfare, as well as investments in capital projects and maintenance. (4) Rising economic dependence on the federal government. (5) Fewer resources to preserve Samoan

culture and the physical environment.

The American Recovery and Reinvestment Act has also provided economic stimulus to the economy through creation of new jobs, construction projects and expansions to various programs. These two events have helped stimulate the local economy and provide jobs however, the long term effects of industry loss and other economic difficulties still remain to be seen.

Cultural and Social Environment

The Samoan culture plays a very significant role in the community and social context. Traditionally, the family and culture are of utmost importance to the people. The Samoan family or "aiga" has strong bonds and is a key factor in both service delivery and patient decision making. Families make decisions together and often important health decisions are made by the family as a group rather than as individuals.

Key members of the Samoan community are family leaders, cultural leaders, and church leaders. The Samoan cultural leaders are the "matai" or the chief of each respective clan or family. Land ownership and family dwellings are also tied directly to family, clan and matai titles where the land is communally owned by the family and under the stewardship/authority of the matai. The matai system provides an extension to the conventional or western idea of families, where any given family or clan includes several households or sections of a village. Respect and compliance for both the matai and/or family leaders such as parents and grandparents are paramount in Samoan society. Matai and family leaders are important members of the Samoan cultural and social environment.

Christianity is the foremost religion in American Samoa. Churches are embraced as an important component of society. Church leaders are revered in all social, cultural and professional settings. Church groups are among the most organized and well attended non-governmental organizations in the community. Most families and individuals are active participants in a church organization of some fashion.

These key factors play an important role in health planning. It is well understood in the health community that any service provided at any level must take into consideration the cultural and social environment of the family. Many of the services delivered at the community level are designed targeting family, cultural, or religious gatherings as most people in American Samoa are active participants in one or all of these groups.

Health Care System

Under the American Samoa legislative code all residents are entitled to free medical care. Therefore all health care services are heavily subsidized by government and delivered at little or minimal cost to residents. Services are administered through the Department of Health and the American Samoa Medical Center Authority. These two agencies are responsible for preventive services and acute care, respectively.

The American Samoa Medical Center Authority (ASMCA), the only hospital in American Samoa, provides all acute medical services and includes outpatient clinics as well as inpatient hospital care. The ASMCA provides outpatient care at the Emergency Room, Primary Care Clinic, Pediatric Clinic, Obstetrics and Gynecology Clinic, Surgical Clinic, Medical Clinic, Ear Nose Throat Clinic, Dialysis Clinic, Psychiatry Clinic, Dental Clinic, and the Eye Clinic. The inpatient services include 109 patient beds in six wards: Labor and Delivery, Nursery, Maternity, Internal Medicine, Surgical, Intensive Care, and Psychiatry. The ASMCA also provides all laboratory, diagnostic imaging, and pharmacy services for the entire population. The ASMCA operates as a semi-autonomous agency of the government and is governed by a board of directors whose membership is subject to legislative approval.

The Department of Health is responsible for preventive services to the community. The Department of Health direct care service in the community based health centers. There are six health centers, spread out geographically throughout the island from the two outer clinics in Manu'a, one on the western end and eastern end of the island, one clinic in the central area close to the capital and the Federally Qualified Tafuna Family Health Center in the most populated area of the island. In 2009 Tafuna Family Health Center added two new access points to its service and has now included the Leone clinic on the western tip of the island, and Amouli clinic on the eastern tip of the island.

The Department of Health is also responsible infectious and chronic disease prevention, community nursing services, environmental health, immunization, Public Health emergency preparedness, cancer control and screening, HIV and STD screening, early intervention and newborn hearing, as well as MCH services.

B. Agency Capacity

/2011/

Two members of the MCH Staff nutrition staff participated in the BodyWorks training course and are now certified trainers for this curriculum. The implementation of BodyWorks training of trainers increases capacity for the MCH Program and all other Department of Health Programs who participated in this training. Several members of the Department of Health staff were also trained as trainers in BodyWorks establishing a cadre of trainers to implement this service.

The MCH have included BodyWorks as planned activity to address nutrition, physical activity and obesity prevention for pregnant women and families accessing MCH services in the coming fiscal year.

//2011//.

C. Organizational Structure

The Department of Health is one of the smaller agencies of government. The Director of Health is appointed by the governor, and subject to confirmation by both houses of the legislature. The Director of Health is a political appointee position, a member of the governor's cabinet and is answerable to the governor.

The Department of Health has taken on new leadership in the form of the new Director of Health. The Department is currently going through a transitional period of reorganization, and the new organization chart is still under construction. A draft of the organizational chart has been attached with the 2011 state grant application; however it is still under discussion. A final version of the organizational chart and other changes within the Department should be finalized by the end of 2010 and will be updated in the next application.

The Department of Health employs just under 200 employees and is a department of the American Samoa Government. The main office is centrally located across the street from the American Samoa Medical Center Authority with community health centers and satellite offices located in other locations.

The MCH Program is one of fifteen federally funded programs operating within the Department of Health. These programs include Immunization, Early Intervention, Comprehensive Cancer Control and Breast and Cervical Cancer screening, Early Newborn Hearing Screening, HIV and STD, Public Health Emergency Preparedness, Tuberculosis elimination, Diabetes Control,

Tobacco Control, Preventive Health Block Grant, and Hospital Preparedness. These programs work under the oversight of the Director of Health and his administration. Currently, the programs work parallel to one another with the Director and administration (including Deputy Director and Medical Director) directly above.

The Deputy Director of Health serves as the MCH/CSHCN and SSDI Program Director. In this capacity she provides administrative oversight but also advocates for MCH services at the highest level within the Department of Health. The MCH Coordinator works closely with and is accountable to the Deputy Director for implementation of activities, fiscal management, program monitoring and planning. Working closely with the Director and Deputy Director is the Public Health Administrator. The Programs also work very closely with the medical staff, and at least one physician has been designated to work closely with each program. The MCH employs two doctors and two nurse practitioners, one of whom provides this type of expertise to the program.

Other key service areas within the Department include the community Nursing Services, which provides nursing staff to all of the community based clinics. Environmental Health services are responsible for safe and healthy environments, and food vendor regulations and enforcement.

An attachment is included in this section.

D. Other MCH Capacity

Title V includes administrative staff who provide oversight and administrative direction, the MCH Coordinator who is responsible for program coordination, as well as clinical and support staff:

Tuiasina Dr. Salamo Laumoli, DO, MPH
Director of Health

Tuiasina Dr. Salamo Laumoli practiced dentistry in American Samoa for over 20 years at the American Samoa Medical Center Authority (ASMCA). He was service chief of the Dental Clinic at ASMCA for many years before his retirement and has a MPH from the University of Hawaii School of Public Health.

Mrs. Elizabeth Ponausuia, MPA
Deputy Director, Department of Health, Program Director -- MCH Program
Ms. Ponausuia has served the Department of Health for many years as the Chief Financial Officer. She has a Masters Degree in Public Administration and was promoted to the post of Deputy Director of Health in 2006. In this capacity she oversees all federal programs including Title V. As MCH Program Director she provides direct supervision of the MCH Coordinator, as well as provide fiscal and programmatic oversight.

Ms. Jacki Tulafono, BS
MCH Coordinator
Ms. Tulafono has worked in the MCH Program since 1997 first as a special project coordinator and now as the Program Coordinator. She is responsible for management and effective coordination of program planning, implementation and monitoring. She provides leadership to the MCH staff, is an advocate for MCH issues within the Department of Health and in intergovernmental and public settings, and serves on a number of councils and work groups to facilitate partnership and cross-collaboration between service providers. Ms. Tulafono is also responsible for the SSDI program and all MCH reporting requirements.

Anaise Uso, BDS - MCH Dentist,
Dr. Anaise Uso is the MCH Dentist who coordinates the MCH School Outreach team. Dr. Uso spends nine months of the year providing preventive health services to school children. She works collaboratively with the outreach team of the ASMCA Dental Services to provide preventive dental services to school aged children. Dr. Uso also works closely with MCH providers to plan and implement oral health activities at the Well Baby and Prenatal Clinics. She also serves in an

administrative capacity with program planning and other MCH infrastructure building activities and represents the MCH Program on various councils and committees.

Ipu Eliapo, OTA
CSHCN Program

Ms. Eliapo has worked with the CSHCN program for several years before leaving island to work on her Master's of Occupational Therapy. She has one more year to complete her certifications and will return to provide OT services to children in the Territory.

Saipale Fuimaono, MBBS
MCH Physician

Dr. Fuimaono is a graduate of the Fiji School of Medicine and is the primary physician for the MCH Program. Dr. Fuimaono was hired to provide direct medical services to the second most populated Well Baby/Child clinic on the island. Additionally, Dr. Fuimaono has provided gap filling medical services for Children with Special Health Care Needs. Dr. Fuimaono also provides clinical expertise in policy and standard development as well as resource for health education.

Olita Laititi, MBBS
MCH Physician

Dr. Laititi is a graduate of the Fiji School of Medicine and is the primary physician for the MCH Program. She provides direct medical services to the infants and children who access the Well Baby/Child Clinic at the Tafuna Family Health Center. She serves the most populated clinic on the island. Dr. Laititi also provides clinical expertise in policy and standard development as well as resource for health education.

Margaret Sesepasara, BSN, MSN
Nurse Practitioner

Mrs. Sesepasara serves as the women's health clinical provider at the Tafuna Family Health Center. She provides prenatal, post-partum, family planning and other women's health services to women who access services at the Tafuna clinic. She also acts as an active educator, coach and advocate for breastfeeding and nutrition.

Tele Hill, NP
Nurse Practitioner

Mrs. Hill is the primary clinical provider of services for Children with Special Health Care Needs. She provides direct services to children and their families at home, school or other settings as is necessary. She also provides Well Baby and Prenatal Care services at the eastern clinic in Amouli. She provides follow up for all high risk and chronic care patients being discharged from the hospital. She works closely with Special Education, Early Intervention, and other community partners to ensure that all CSHCN are seen and re-assessed on an annual basis.

Rosita Alailima-Utu, BSN

Mrs. Utu is the senior health educator for the MCH Program. She helps coordinate health education efforts in all areas of maternal and child health. Mrs. Utu works directly in the clinics to provide health education in both group and individual settings. She also provides breastfeeding mentoring and coaching to new mothers.

Mary Time, LPN
Women's Health Nurse

Mrs. Time has many years' experience working in the Family Planning clinic providing education and contraceptive services. She is now also working in the Prenatal/Post partum clinic by providing contraceptive education and services, as well as Hepatitis B vaccinations. She also provide women's health education in this capacity.

Luana Leiato,

Nutrition Educator

Mrs. Leiato is one of the education team, with emphasis on breastfeeding, nutrition and physical activity. Luana works primarily out in the clinics to provide health education in the areas of women's and child health. Mrs. Leiato is one of the certified trainers for the BodyWorks curriculum. She works very closely with Mrs. Utu and Mrs. Alailefaleula.

Conference Alailefaleula, Nutrition Educator

Mrs. Alailefaleula is one of the education team, with emphasis on breastfeeding, nutrition and physical activity. She works primarily out in the clinics to provide health education in the areas of women's and child health. She works very closely with Mrs. Utu and Mrs. Leiato.

Anetta Pele, Temukisa Sauni, Faafetai Meleisea Community Health Assistants

These three individuals are health assistants who work in three different areas. All have received training similar to that of a certified nurse's assistant for clinical services such as taking vitals and providing health education, as well as data collection and entry.

Vacant Positions:

MCH Nurse -- to assist with work load at the Well Baby Clinics

Dentist -- to work with the School Outreach Team providing 3rd grade dental sealants

Dental Assistants (2) -- to work with the School Outreach Team

Nutritionist -- to fully staff health education team addressing MCH education issues.

E. State Agency Coordination

/The following Territorial Human Service Agencies are represented in American Samoa and are all under the jurisdiction of the Territorial government. The Department of Health MCH Program has long standing working relationships with all of these agencies and has included these agencies in the recent Title V Needs Assessment just completed. Each of these agencies are also members of the MCH Advisory Council to ensure that all MCH services are well coordinated and to enable the pooling of resources and information across agencies.

1. Department of Health -- the MCH Program coordinates services and activities with the following programs of the Department of Health:

a) Part C - The MCH Coordinator is a member of the interagency council for Part C. Title V staff who work with CSHCN coordinate services with Part C in the development of the Individual Family Service Plans. Part C staff provide services to the Title V population. (play therapy, assistance in the development of Individual Family Service Plans etc.)

b) Tafuna Family Health Center (Federally Qualified Health Center) -- the MCH Program coordinates with the Tafuna Family Health Center to provide Women's Health, Well Baby and Well Child, Oral Health, and Health Education services. The Health Center is situated in one of the most densely populated and congested areas on the island, serving a population which is considered high risk for negative health outcomes; while the two new access points are located at the far east and far western ends of the island.

c) Immunization Program -- The MCH program partners with the Immunization program to ensure that infants and children receive age appropriate immunizations through direct services in the dispensaries as well as enabling services such as health education. Efforts are also made to combine resources towards an electronic database that will enable more effective monitoring of immunization coverage status in the community.

d) Nursing Services -- The MCH Program continues to collaborate with the Immunization Program and Nursing Services to maintain immunization coverage in the community by offering

free Well Baby/Child services, offering health education and public awareness on the importance of immunizations for children, and provide follow-up of children who have missed their scheduled vaccinations. The MCH Program provides infrastructural support by providing and maintaining a database in each of the dispensaries that enables the nurses to look up individual records with ease, generate lists of children expected on any given date and a list of those who missed their appointments.

Title V staff also collaborate with the Nursing Services in the coordination and implementation of the Filariasis Elimination Mass Drug Administration Campaign. MCH staff continues to volunteer time after regular working hours to support this campaign.

e) Diabetes Control Program - Title V coordinates with the Diabetes Control Program and has assisted in the creation of a system of care for gestational diabetics. Gestational diabetes, early initiation of prenatal care, and proper nutrition are emphasized in a weekly health education show aired on public television hosted by the MCH Nurse Practitioner. Additionally, the MCH Nurse Practitioner serves as a member of the National Diabetes Education Program.

2. American Samoa Medical Center Authority (ASMCA) -- the following divisions of ASMCA directly serve the Title V target populations:

a) Management of Information Systems (MIS) Department works with Title V by providing opportunities for tele-health video conferencing. This enables the Title V staff to consult with off-island consultants, participate in continuing education workshop opportunities etc. Further, the Department of Health has a signed MOU with ASMCA and the MCH Information Systems project to share access and resources around the electronic medical records system currently in use. MIS also provides technical and administrative support to ensure data linkages and sharing of electronic medical records system.

b) The OB/Prenatal Care Clinic provides prenatal and postpartum care for the population of pregnant women living in the service area as well as follow up for high-risk cases which are referred to that Clinic.

c) Mental Health Services possess the ability to diagnose and administer treatment to mentally ill clients.

d) Title XXI - Family Planning - Provides family planning services to the population of Title V. The MCH Program also continues to play an active role on the Teen Pregnancy Prevention Coalition each year. The coalition is a collaborative effort between the Department of Health, AS Medical Center Authority, and other community agencies to prevent teen pregnancies. The coalition works with church, youth and community groups to promote awareness about teen pregnancy.

e) The Dental Clinic and the Department of Health has a collaborative program to provide free preventive dental services to school children whereby the Dental Clinic provides dentists and dental assistants to coordinate with MCH personnel during the school year for outreach dental services targeting 3rd grade and Head Start children in the Territory.

f) Pediatric Department and the Department of Health maintain a strong collaborative relationship to effectively serve the children in American Samoa by coordinating clinical and community-based services.

g) Medicaid and SCHIP - The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 87% of the population has incomes at or below 200% of the federal poverty level. The American Samoa

Government provides all health care services at little or no cost; everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

3. DEPARTMENT OF HUMAN AND SOCIAL SERVICES - delivers services to the Title V population and provides necessary data items in satisfaction of federal data requirements. The MCH Coordinator is the Department of Health representative to the First Lady's youth substance abuse prevention initiative (Taitaitama) executive board to coordinate services for adolescents. Members of the DHSS staff are also on the MCH Advisory Council to ensure service coordination and stakeholder buy in. The following divisions of the Department directly serve the Title V population:

a) WIC - the Supplemental Feeding Program for Women, Infants and Children offers nutritional education and counseling for mother and baby, breastfeeding education, plus developmental information about babies. WIC assists the Title V Program to meet federal data reporting requirements.

b) Developmental Disabilities Planning Council - acts as a member of the interagency team focused on meeting the needs of children with special health care needs. Assists families in the development of the Individual Service Plans.

c) Teen Substance Abuse Prevention Program -- serves the adolescent population of the Territory through community-based coalitions and government agencies including MCH focusing on preventing the use of alcohol and tobacco and illicit drugs among school aged teens.

d) Child Protective Services (CPS) -- The Department of Health is working closely with CPS on the interagency collaborative for MCH Home Visiting Program to provide child protective services to families deemed as high risk and eligible for home visiting services.

e) Substance Abuse Counseling and Treatment - The Department of Health is also working collaboratively with substance abuse services on the interagency collaborative for MCH Home Visiting Program to provide these services to families deemed as high risk and eligible for home visiting services

4. DEPARTMENT OF EDUCATION -- provides the MCH Program with pertinent data from the YRBS, assists in the enforcement of the child immunization law, and assists in the coordination of the Children's Oral Health School Outreach Team as well as other school-based health education activities. Members of DOE are also on the MCH Advisory Council. The following divisions of the Department of Education directly serve the Title V population:

a) Office of Curriculum, Instruction and Accountability (OCIA)-- MCH staff work very closely with OCIA staff to plan and coordinate health activities implemented with the schools. These activities include child obesity prevention activities, the annual wellness fair, nutrition work group, and discussion of the YRBS survey implemented by OCIA at the schools.

b) Early Childhood Education - Assists in the enforcement of the Immunization law prohibiting children from entering school without immunization program clearance.

c) Elementary Education - assists in the enforcement of the Immunization Law prohibiting children from entering school without complete immunizations, assists families in the development of Individual Service Plans.

d) Special Education - Assists in meeting the service needs of the CSHCN population, assists in

assuring that all services are provided to the CSHCN population, acts as a key member of the interagency team focused on the needs of CSHCN, assists in the development of Individual Service Plans for families of CSHCN.

5. **CENTER FOR FAMILIES OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (CFIDD)** -- The Department of Health maintains a strong collaborative relationship with CFIDD, the community family advocacy group currently active in the Territory. CFIDD personnel are also included in MCH home visits to CSHCN children and their families. This joint effort helps avoid confusion among the parents regarding different service providers in the community.

6. **INTERAGENCY LEADERSHIP COUNCIL** -- The MCH staff continue to be active members of the Interagency Leadership Council which includes Vocational Rehabilitation, Special Education, the University of Hawaii Center for Excellence in Developmental Disabilities, the Development Disabilities Planning Council and other service providers who are involved in school and work transitioning/placement for CSHCN.

AMERICAN SAMOA COMMUNITY COLLEGE -- The Department of Health has fostered several working relationships with programs from the local community college. The MCH Program has a Memorandum of Understanding with the Gear Up Program, and also works closely with the Community Natural Resources Department Nutrition and Research divisions. ASCC also has membership on the MCH Advisor council.

a) **Gear Up** - The Department of Health has been an active partner in the Gear Up Program for five years. Gear Up is a cohort college preparatory program for underserved children. Gear Up provides educational support to its cohort, now in the 11th grade to increase their success in both high school and college careers. Social supports are provided by Gear Up partners such as Department of Health and Department of Human and Social Services to address health and social issues for these children and their families.

b) **Community Natural Resources (CNR)** -- Department of Health works closely with the CNR Research division on a number of research projects in MCH. One of the more prominent research projects is Dr. Don Vargo's childhood obesity study that has been published and is now widely used in the Department of Health. CNR also has the Expanded Nutrition Program that promotes health cooking and vegetable gardening in the community. MCH coordinates activities with both of these divisions to promote healthy nutrition, physical activity and to share data sources.

F. Health Systems Capacity Indicators

Introduction

//2011/

It is significant to note for the Systems Capacity Indicators there are some difficulties in reporting on the Medicaid and SCHIP measures. Unlike the Medicaid and SCHIP programs in most States, the American Samoa Medicaid funds are awarded in the form of a grant. The grant funds are then used to administer medical and dental services. The American Samoa government is the provider of all medical and health services through the ASMCA (hospital) and the Department of Health. Anyone who accesses these services is served on a basis of presumed eligibility, rather than individual enrollment. Therefore it is not feasible to make comparisons between these populations.

There have also been changes and improvements in data reporting for the HSCI's such as HSCI 1 and 4. It is anticipated that through coordinated efforts with partner agencies such as the ASMCA and the Department of Education will build data linkages and capacity.

//2011//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	0.0	162.6	160.9	25.6
Numerator	0	0	143	152	16
Denominator	8941	8872	8796	9445	6256
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

There is a discrepancy in the data reported for this measure in both numerator and denominators. The discrepancies are attributed to reporting issues each year. The denominator data were different population estimates, the number reported for 2009 was based on the 2000 Census. The number reported for 2008 was based on an inter-census estimate. The number of reported cases are from the discharge data reported by the hospital.

Notes - 2007

Data for Year 2007 for this performance measure was not available at the time of this report. Data will be reported as soon as it becomes available.

Narrative:

/2011/

The Cancer Coalition and the Comprehensive Cancer Control Program have introduced The Smoke Free Environment bill into the legislature. The Smoke Free Environment bans smoking in all public places. The bill is in its second reading this year and it is anticipated this bill will be enacted into law in the coming years. The Comprehensive Cancer Control program is currently working on the awareness campaign and enforcement plans associated with the Smoke Free Environment Act. The Comprehensive Cancer Control Program is one of the MCH partners in prevention of tobacco use among teens and families to promote clean air.

//2011//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	100.0	90.7	71.7	63.3	65.5
Numerator	1726	1417	926	1315	1362
Denominator	1726	1562	1291	2078	2078
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

The denominator for this measure is a mid-sensus estimate, and the numerator is the number of children seen by MCH in the Well Baby Clinics. There is no Medicaid eligibility criteria, therefore impossible to report for this measure.

Notes - 2008

The denominator for this measure is a mid-sensus estimate, and the numerator is the number of children seen by MCH in the Well Baby Clinics. There is no Medicaid eligibility criteria, therefore impossible to report for this measure.

Notes - 2007

This indicator does not apply to American Samoa due to its unique Medicaid program. The data reported for this measure are the number of infants screened at the Well Baby clinics. More specifically, this data was collected from only two Well Baby Clinics, Tafuna Family Health Center and CII (Central). Thus the reason for the significant drop in data reported. Data from Amouli and Leone clinics are not available at this time. Once it is available it will be reported.

Narrative:

/2011/

The Medicaid Program in American Samoa is unique, and the only one of its kind that is awarded in a grant form, requiring a state match. These Medicaid funds are currently administered by the American Samoa Medical Center Authority, and utilized to provide direct services there.

The data reported for this measure reflects the total number of infants served at the Well Baby Clinics, over an inter-census estimate of the number of one year olds. All infants attend Well Baby Clinic and receive early screening at the scheduled one month of age, represented by this data.

//2011//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	100.0	90.7	71.7	63.0	65.3
Numerator	1726	1417	926	1315	1362
Denominator	1726	1562	1291	2087	2087
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

The denominator for this measure is a mid-sensus estimate, and the numerator is the number of children seen by MCH in the Well Baby Clinics. There is no Medicaid eligibility criteria, therefore impossible to report for this measure.

Notes - 2008

The denominator reported for 2008 is a mid-census population estimate for the number of infants less than 1 year of age. The numerator is the number of children seen by MCH in the Well Baby Clinics, as there is no Medicaid or SCHIP eligibility criteria.

Narrative:

/2011/

The Medicaid and SCHIP Programs in American Samoa are unique, awarded in a grant form with a required state match. These SCHIP funds are currently administered by the American Samoa Medical Center Authority, and utilized to provide direct services there.

The data reported for this measure reflects the total number of infants served at the Well Baby Clinics, over an inter-census estimate of the number of one year olds. All infants attend Well Baby Clinic and receive early screening at the scheduled one month of age, represented by this data.

//2011//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	14.7	18.8	22.1	19.5	70.3
Numerator	73	103	96	225	471
Denominator	496	547	435	1153	670
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

American Samoa does not collect birth data on the current birth certificate. Therefore those data are not available from vital statistics. The data reported for this measure is a sampling of post partum records with completed data, meaning all data field required to calculate the KI was documented.

Notes - 2007

Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

Narrative:

/2011/

There is a noticeable difference in this indicator between reporting periods 2008 and 2009. There was a significant difference in the level of reporting from year to year. The data for 2009 was complete for more records than in 2008.

However, there is also a marked increase in the number of women who received the number of visits expected during her pregnancy. This is attributed to the financial incentive package implemented by the ASMCA, where women receive a discounted rate for inpatient stays if they are early and consistent with their prenatal visits.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	6094	4972	4756	4598	4598
Denominator	6094	4972	4756	4598	4598
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

This data is reported from children seen by MCH at the Well Child Clinics, where 100% of children are presumed Medicaid eligible.

Notes - 2008

This data is reported from children seen by MCH at the Well Child Clinics, where 100% of children are presumed Medicaid eligible.

Notes - 2007

The data reported are children served at the Well Baby Clinics whom are presumed 100% eligible.

Narrative:

Although Medicaid and SCHIP measurement is not feasible, the MCH Program continues to serve children through Well Baby/Child services that are available at all of the health centers and dispensaries. Health assessments, education, nutrition counseling, and immunizations are among the services received by this population.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	63.7	43.0	56.6	60.7	50.6
Numerator	382	626	810	639	540
Denominator	600	1455	1430	1053	1067
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009

The data reported for this measure reflects the number of 3rd grade children seen by the School Outreach team. Second grades were also seen but data is not yet available. There is no Medicaid/SCHIP eligibility criteria, all children are presumed eligible.

Notes - 2008

The data reported for this measure reflects the number of 3rd grade children seen by the School Outreach team. There is no Medicaid/SCHIP eligibility criteria, all children are presumed eligible.

Narrative:

This data reflects 3rd grade children screened by the MCH dentist during school outreach visits. These children received a dental assessment, fluoride varnish and oral hygiene education along with toothbrushes and floss with a dental report card for parents. These services will continue in 2011, as MCH is in the process of hiring more staff for the dental outreach team.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1	1	1	1	1
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes		
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

This measure does not apply to American Samoa as we are not eligible for SSI.

Notes - 2008

American Samoa is not eligible for SSI, this measure does not apply.

Notes - 2007

This measure does not apply to American Samoa as we are not eligible for SSI.

Narrative:

American Samoa does not have SSI.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				MEDICAID	
Percent of low birth weight (< 2,500 grams)	2009	other			1

Notes - 2011

Data source: Usually obtain this data from vital statistics but it was not available at this time, so this percent is provisional

Narrative:

/2011/

This measure is not applicable to American Samoa. The Medicaid Program in American Samoa is unique, and the only one of its kind that is awarded in a grant form, requiring a state match. These Medicaid funds are currently administered by the American Samoa Medical Center Authority, and utilized to provide direct services there.

The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program. The current estimate is that 87.7% of the population is at or below 200% of the federal poverty level, and this is the proportion used for presumed eligibility. The American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital to subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

//2011//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2009	other			11.6

Notes - 2011

Data source: HISO-ASHA for both numerator and denominator

Narrative:

This measure is not applicable to American Samoa.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	other			23.1

Notes - 2011

Data source: MCH Data system

Narrative:

This measure is not applicable to American Samoa.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	other			70.3

Notes - 2011

Data source: MCH Data system

Narrative:

This measure is not applicable to American Samoa.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2009	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP

Infants (0 to 1)	2009	200
------------------	------	-----

Notes - 2011

Data source: vital statistics

Narrative:

This measure is not applicable.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 2 to 5) (Age range 6 to 9) (Age range 10 to 21)	2009	200 200 200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 2 to 5) (Age range 6 to 9) (Age range 10 to 21)	2009	200 200 200

Notes - 2011

Data source: census estimates

Narrative:

This measure is not applicable.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2009	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2009	200

Notes - 2011

Data source: MCH Data system

Narrative:

This measure is not applicable.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:

The MCH Program maintains partnerships with the American Samoa Medical Center to continue to develop data linkages through administrative and technical mechanisms. There is currently a Memorandum of Understanding with the ASMCA on data sharing. This relationship continues to be developed to meet the health needs of the community by improving data systems.

The Department of Human and Social Services is also a key partner with Department of Health. Administrative agreements and data linkages will be developed further, as both agencies are building data infrastructure and capacities.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
---------------------	---	---

Youth Risk Behavior Survey (YRBS)	3	Yes
-----------------------------------	---	-----

Notes - 2011

Narrative:

The MCH Program continues to partner with the Department of Education on health related activities. The YRBS data is made available to the MCH Program as a health partner and a member of the Health and Science work group.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2011/

Program priorities that were identified in the prior needs assessment were maintained during the last 5 year period. Many of these issues have been converted into new priorities and state performance measures as they remain to be of concern and warrant effort.

Following the prioritization process of all areas of need identified there was careful examination of each need, the service capacities to address the need, including current efforts as well as gaps, and the effectiveness and/or impact of services. The list of priority needs is a result of a lengthy discussion of all partners assembled at the final needs assessment planning session.

Some priorities weighed more heavily in the discussion than others. For example, immunization was selected after a discussion on the effectiveness of the interventions and the resources allocated for the intervention. Others, such as teen pregnancy, were not chosen because the group decided that it would continue to be addressed as a national performance measure and did not warrant additional importance.

The MCH Program recognizes that adolescent health issues were not highlighted in the plan for the coming year. It is also acknowledged that the capacity to address adolescent health issues is not adequate to meet the needs of this population. Current efforts will continue such as outreach activities to Gear Up students and the Teen Pregnancy Prevention Coalition. The capacity to meet the needs of teens in American Samoa will continue to be developed through infrastructure building efforts and policy development.

//2011/

B. State Priorities

The program priorities as identified and ranked during the 2010 Needs Assessment were:

PRIORITY NEEDS	SERVICE LEVEL
Increasing immunization coverage for young children.	Population-based
Increasing adequacy of prenatal care for pregnant women.	Direct Services
Improving BMI of children 2-5 years old.	Enabling Services
Improving nutritional status of 1 year olds.	Direct/Enabling Services
Increase the number of infants who are breastfed.	Direct/Enabling Services
Improve oral health of children 0-5 years.	Population-based
Improve services for Children with Special Health Care Needs.	Direct Services

These priorities were used to develop State Performance Measures. Most of the priorities are directly addressed in the State Performance Measures. Although not all priorities are included as State Performance Measures (such as oral health and breastfeeding), these priorities are addressed in the National Performance Measures. Efforts to address those needs are included in discussion of the National Performance Measures.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0		10	0	0
Annual Indicator	0.1	0.1	0.0	0.0	0.0
Numerator	1	1	0	0	0
Denominator	1720	1442	1291	1338	1361
Data Source				Newborn records	Newborn records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	0	0	0	0	0

Notes - 2008

AS does not have a state mandated newborn screening program.

Notes - 2007

AS does not have a state mandate newborn screening program.

a. Last Year's Accomplishments

American Samoa does not conduct newborn metabolic screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. American Samoa does not have a State mandated newborn screening program. The MCH program will review all data items currently collected that are appropriate for this measure and report them in the coming annual report.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

American Samoa does not conduct newborn metabolic screening.

c. Plan for the Coming Year

American Samoa does not conduct newborn metabolic screening.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	1361					
Reporting Year:	2009					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)		0.0				
Congenital Hypothyroidism (Classical)		0.0				
Galactosemia (Classical)		0.0				
Sickle Cell Disease		0.0				

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	35	45	45	90	90
Annual Indicator	35.0	35.0	89.3	89.3	75.0
Numerator	21	21	125	125	30
Denominator	60	60	140	140	40
Data Source				CSHCN Program records	CSHCN Program Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	75	77	79	80	85

Notes - 2009

This data was reported by the CSHCN team after completing a telephone survey of 40 families. This is 27.4% of the total CSHCN population. Results showed that over half (of those surveyed) were very satisfied, 18% were somewhat satisfied, 7% were not satisfied.

Notes - 2008

The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

a. Last Year's Accomplishments

The CSHCN team reported that all 146 clients (100% coverage) received health care services with full participation and consent of their parents/caregivers and families. The team believes that this success was due mostly to the convenience of providing annual physical check-ups in the school setting, a collaborative effort with the Department of Education's Special Education Program and the MCH Dental team.

Families expressed their appreciation and satisfaction regarding the services provided such as assistance with travel to and from home for required appointments at the hospital, ensure that they are seen by off-island specialists when visiting the territory, receive additional home care, feeding and nutritional guidance, and also for moral support and counseling especially during the September 29th Earthquake and Tsunami aftermath.

The CSHCN staff continued to work closely with the Part C Helping Hands Program, utilizing the services of their physiotherapist, and visiting off-island specialists for feeding and hearing testing. Children discharged home with tracheotomies received close care with frequent suctioning, oxygen refills, level monitoring, and feeding-tubes were assessed for swallowing competencies. By continuing to collaborate with other agencies, including full participation of clients' families in decision-making, this enabled a very successful partnership in delivering of services.

Transportation for clients is an enabling service that the program continue to provide for clients who need them. This is to ensure that clients are able to travel to and from home for appointments, hospital discharges, daily intramuscular medications at home to avoid prolonged hospital stays, moral support and any other care needed and requested by its clients.

The program together with its interagency partners was very active in providing orthopedic care for its clients when the Shriner's from Hawaii visited American Samoa for their annual visit. Appointments were made, transportations were provided as needed, and the clinic was manned for two to three days by the program, its partners and the LBJ staff. Off-island referrals were scheduled as directed by Shriner's and help was provided for visas and other travel documents as needed. Wheelchairs and other equipment from Shriner's were also assembled, reconstructed, maintained and distributed as directed. Ongoing contacts with Shriner's were established for follow up care locally and in Hawai'i.

The same procedures and activities were done when other specialists visited American Samoa. CSHCN Clients were seen by Pediatric cardiologist, urologist, the Head Neck Ear Eye Nose, throat and hearing specialists. Health education given by specialists was translated to Samoan as needed. This included education on new prosthesis, medications, procedures and whatever care parents and caregivers were not familiar with. Ongoing assistance continued until families were confident and proficient in providing adequate home care.

Despite this reported success, the survey carried out back in September 2009 indicates that there are families whom are not completely satisfied with services provided. Even though there is parental consent for check-ups at school, only a few parents are present and clients' medical status is discussed. When parents are not present and problems were noted, they were notified by the program and the teachers to discuss solutions. This leaves out parents of clients who have no apparent medical problem and if they do not voice any of their concerns then their children's

needs (if any) may not be heard nor met.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program ensures families are involved in decision making around the services they receive and are entitled to.	X			
2. The CSHCN Program has increased capacity of services by adding a physician and dentist to the service team for children and their families.	X			
3. The MCH Program continues to recruit a nurse for the CSHCN program and will continue to so until the position is filled.				X
4. The CSHCN Program will conduct the SLAITS-like survey in order to determine the percentage of families who are satisfied with the community service systems.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to program protocols, the CSHCN staff continues to provide medical home care, using standardized assessment tools and evaluations. Its interagency partnerships continue to strengthen as they work together in sharing and utilizing each other's resources and expertise to provide the appropriate services for their clients. Majority of clients who actively attends school (elementary and high school) are seen at each of their respective schools for their annual medical evaluations.

With the recent September 29 local disaster, partners and stakeholders all agreed the community needed some mental assessment and intervention. Fortunately, the Department of Human and Social Services held workshops on stress management and disaster preparedness. All related programs invited families and care givers to attend these workshops. Over 30 couples and caregivers attended and was quite a success with play acting and actual hands on practice performed by the trainers.

The program staff reported that they were very fortunate to have the MCH consultant, Dr. Ichiho, provide technical assistance and Needs Assessment training. At the end of Dr. Ichiho's training, staff and existing partners were more confident in collecting more meaningful data, agreed to meet regularly to share information, and discuss way to provide better services for its clients.

c. Plan for the Coming Year

The CSHCN staff plans to carry out the followings:

1. Update clientele information.
2. Arrange and schedule timely orderly appointments so each client will receive a medical evaluation either at home or at school.

4. Continue to promote attendance of clients and their families for all off island specialists' visits that provide care locally. CSHCN staff will partner with each specialty area and help run the clinic so all CSHCN clients are a priority and included.

5. Provide parent trainings through parent meetings, three times a year. This will ensure that all families are adequately receiving care, aware of how to care for their loved ones at home, and familiarize with all services that are available to them and by which program/partner. Examples of topics are:

- Feeding techniques
- Transfers from w/chairs to bed/visa versa
- Bed baths/pressure area cares/oral hygiene/linen changes
- Tracheotomy care
- Inhalation therapy
- ROM exercises
- Nutrition
- Occupational therapy
- Physical therapy
- Each Agency to offer training specialty in area of expertise

6. Familiarize families with nearest community health center for care as needed

7. Conduct CSN survey at Parent Meetings to evaluate satisfaction with services received

8. Create, pilot test& disseminate, brochures/ pamphlets that encompasses important information from each CSN Partner :

- Patients' rights
- Nutrition
- Related services available

9. Ensure that Video Teleconferencing is available for staff and partners to improve service capacity

10. All trainings will be documented and reported to the MCH Coordinator in a monthly basis.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	98	65	90	90
Annual Indicator	54.8	85.7	89.3	89.3	20.0
Numerator	80	120	125	125	8
Denominator	146	140	140	140	40
Data Source				CSHCN Program	CSHCN Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100

Notes - 2009

This data was reported by the CSHCN team after completing a telephone survey of 40 families. This is 27.4% of the total CSHCN population. 20% of those surveyed reported that services were coordinated and comprehensive within a medical home.

Notes - 2008

The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

a. Last Year's Accomplishments

All CSHCN clients (100%) received coordinated, ongoing, comprehensive care within a medical home. By expanding the services for home visits and school visits this enable all clients to be served. This past year staffing has continued to be a problem as in the past few years. This did not hinder progress or work to serve the CSHCN children and to maintain the "medical image" of the program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN staff continue to work with the other service providers such as Early Intervention and Special Education to ensure services are provided to all children.				X
2. The MCH Program is an active member of the Interagency Leadership Team which coordinates planning activities for children and families with special needs.				X
3. The CSHCN staff provide workshops for parents and caregivers of infants and toddlers enrolled in the early intervention program on topics appropriate to their needs (hygiene, feeding, positioning, etc).				X
4. The MCH Program continues to recruit a nurse for the CSHCN program and will continue to so until the position is filled.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The program again teamed up with Part C Helping Hands (Early Intervention) program and conducted visits through encounters at the pediatric ward, clinics, off island specialists' visits and where ever the children may be. The program took care of all intensive comprehensive care of clients who wished to be discharged home, and whose care givers are not trained to perform special procedures on their own. It has been instrumental in training the families until they are proficient and are capable. Program staff also solicits the community for funding to procure equipment for home care such as a suction machine, an oxygen tank, and tracheal tubes. Almost 90% of the time the families do not have the means to purchase them. The CSHCN nurse also volunteers to standby for any emergency calls. The families are also trained to call 911 for emergencies. EMS staff stationed close by the particular homes, are also alerted about such cases.

Together with the dental program, CSHCN staff continues to visit different schools to perform physical and dental exams for children with parental consent. Parents and/or caregivers are encouraged to be present to discuss and answer any questions they may have regarding the care of their children.

The CSHCN staff has also been working with the MCH consultant from Hawaii to improve and broaden their knowledge on conducting needs assessment, data collection, analysis, reporting, and much more to improve service capacity.

c. Plan for the Coming Year

With new staff increase, program staff plans to provide a more ongoing coordinated and comprehensive plan for each CSHCN. If staffing shortage continues to be an issue for the MCH program, the CSHCN team will join efforts with other service and outreach programs such as the MCH Dental Outreach Team, the Immunization Program, Early Intervention and the Center for Families of Individuals with Developmental Disabilities in order to provide services to all CSHCN and their families. All clients will receive annual physical examinations at school settings and preferably at homes with caregivers in attendance. The MCH Health Educator, Mrs. Rosita Utu will continue to assist the CSHCN family nurse practitioner, Mrs. Hill, to schedule future appointments with caregivers by telephone, at meetings or at trainings.

All examinations and referrals will be documented and reported monthly to the MCH Coordinator by the CSHCN nurse practitioner. The master list of all clients will be revised and updated monthly by the CSHCN staff and its partners to ensure that all current and potential clients are served in an efficient and appropriate manner.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	146	140	140	136	146
Denominator	146	140	140	136	146
Data Source				CSHCN Program	CSHCN Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100

Notes - 2009

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

a. Last Year's Accomplishments

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program will conduct the SLAITS-like survey in order to determine the percentage of families who are satisfied with the community service systems.		X		
2. The MCH Program continues to recruit a nurse for the CSHCN program and will continue to do so until the position is filled.		X		
3. The MCH Program is an active member of the Interagency Leadership Team which coordinates planning activities for children and families with special needs.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

c. Plan for the Coming Year

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	60	60	43	43
Annual Indicator	51.7	50.0	42.9	42.9	75.0
Numerator	31	30	60	60	30
Denominator	60	60	140	140	40
Data Source				CSHCN Program	CSHCN Program Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	45	45	50	50	50

Notes - 2009

This data was reported by the CSHCN team. The same percentage of those who reported satisfactory with services they received, also thought that the community-based service systems were also organized.

Notes - 2008

The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

a. Last Year's Accomplishments

The CSHCN Team coordinated with other agencies and service systems in the community to ensure that services for CSHCN are coordinated and comprehensive. The CSHCN staff continued to partner with families and service agencies to ensure comprehensive and timely delivery of necessary services for CSHCN. The addition of a new physician to the CSHCN team had increased the capacity for serving children and their families. The newest team member Dr. Olita Koria works at the Tafuna Family Health Center Well Baby/Child Clinic where she provides

assessments for children and their families. She also attends pediatric grand rounds to ensure she is aware of children who require special services who are either in the hospital or who may be discharged to her district.

There are four outer health centers in the Tutuila community and four in the Manu'a islands, thus access to care was not an issue. Well baby clinics and immunizations are also provided at these areas. A medical doctor or nurse practitioner is usually present to provide care. Program staff has educated and trained the CSHCN clients' families about bringing their children to the centers for care to be familiar with their health centers (medical homes).

The MCH program also worked collaboratively with the University Center for Excellence in Developmental Disabilities to co-sponsor a Related Services Training for community and family members, day care providers, special education teachers, health care providers including MCH staff and various service professionals. This three day training focused on Person-centered planning, Characteristics of Disability, early identification/child find, feeding and positioning for children with special health care needs, hospital-home transitioning, and developing/facilitating communication skills for CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN staff work closely with other service agencies to provide coordinated, user-friendly services to all children with special health care needs and their families.				X
2. The MCH Program continues to serve as a medical home by providing ongoing assessments, gap filling medical services, for children with special health care needs in the home, school and respite care settings.		X		X
3. The MCH Program is an active member of the Interagency Leadership Team which coordinates planning activities for children and families with special needs.		X		X
4. The CSHCN staff provide workshops for parents and caregivers of infants and toddlers enrolled in the early intervention program on topics appropriate to their needs (hygiene, feeding, positioning, etc).		X		X
5. The MCH Program continues to recruit a nurse for the CSHCN program and will continue to so until the position is filled.		X		X
6. The CSHCN Program will conduct the SLAITS-like survey in order to determine the percentage of families who are satisfied with the community service systems.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN team continued the above activities in 2010. The Program also continued to recruit necessary staffing to ensure these services are provided. As recruitment and hiring remains a challenge, the program partnered with the Developmental Disabilities Planning Council and the Interagency Leadership Team to hire the necessary staff for the CSHCN program, yet was not able to recruit new staff.

c. Plan for the Coming Year

The program staff plans to continue encouraging all CSHCN families to be self sufficient in the care of their children and to learn to utilize the community based clinics as much as possible for convenience. The CSHCN team will continue to coordinate with other agencies and service systems in the community to ensure that services for CSHCN are coordinated and comprehensive.

Annual CSHCN survey will again be conducted by the CSHCN staff and its partners at Parent Meetings and trainings to evaluate progress of the usage of services. This will be held every third week of October 2010, February 2011, and June 2011.

Needs and gaps identified in the survey will be addressed by the CSHCN team, all related partners and stakeholders. Activities will be ongoing throughout FY 2011. Such services will assist in ensuring that services are being readily accessible and utilized by clients and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	50	22	23
Annual Indicator	0.0	0.0	21.4	21.4	61.5
Numerator	0	0	30	30	8
Denominator	146	140	140	140	13
Data Source				CSHCN Program	CSHCN Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	63	65	67	69	70

Notes - 2009

This data was reported by the CSHCN team. It is reported that 13 clients were identified as youth in need of transition. Only 8 clients were successfully transitioned.

Notes - 2008

The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

a. Last Year's Accomplishments

The MCH staff continued to be active members of the Interagency Leadership team which includes Vocational Rehabilitation, Special Education and other service providers who are

involved in school and work transitioning/ placement. One of the program's policies is to ensure that appropriate referrals for all adolescent clients to the appropriate agencies for school/work transition. CSHCN also facilitated transition between pediatric and adult medical services by maintaining close working relationship with the staff of LBJ Medical Authority medical staff.

A total of 13 clients should have been transitioned. Only 8 children completed transitioning from the pediatric to the medical clinic for adult care. Parents usually take their own children to the adult clinic where physicians after reviewing each individual's case continue to provide and manage their medical needs. During high school physical examinations, if the parents are present they are briefed about transitioning to the adult medical care clinics for continuation of care. Some parents already have their own favorite doctors they want to take their children to.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program will conduct the SLAITS-like survey in order to determine the percentage of families who have received transitional services.				X
2. The MCH Program continues to recruit a nurse for the CSHCN program and will continue to so until the position is filled.				X
3. The CSHCN Program will work collaboratively with Special Education and Vocational Rehabilitation to facilitate appropriate transition for adolescents with special health care needs.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN staff and its partners are currently creating a protocol for the Health System in American Samoa, which will have the ability to identify clients who are eligible for transitioning. This is to ensure that the proper healthcare providers are notified and thus will take further actions appropriately.

c. Plan for the Coming Year

The CSHCN team will continue to work closely with the LBJ Hospital's medical staff, DOE Special Education, University Center for Excellence in Developmental Disabilities, the Interagency Leadership team, and Vocational Rehabilitation to facilitate and coordinate smooth transitioning of adolescent clients.

The Program will also continue to recruit necessary staffing to ensure these services are provided.

The following activities will continue next year, 2011:

1. Complete policies and procedures for transitioning of CSN clients:
 - Pediatric to Adult Medical Care
 - Vocational Rehabilitation/ Work Placement
 - Elementary School to High School

2. Establish "Transition day" meetings in a comprehensive and systematic manner. All CSHCN partners will meet quarterly (or every other month depending on how often clients need transition) beginning October 2010, to review list of clients, determine who needs transitioning, what types of services needed and who to refer them to.

3. All transitioning services made possible will be documented by CSHCN staff and reported to the MCH coordinator in a monthly basis.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	85	75	72	73	70
Annual Indicator	75.1	70.3	69.7	68.9	56.0
Numerator	1868	1684	1667	1540	540
Denominator	2488	2396	2390	2234	965
Data Source				Immunization Coverage Survey	Well Baby Clinic records for Amouli, Tafuna and Le
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	60	62	62	64	65

Notes - 2009

This data was generated from the community health centers' Well Baby Clinic records, in Amouli, Tafuna and Leone. The ASIP have yet to finalize their report for their 2009 survey.

Notes - 2008

This data was reported by the ASIP after completing an immunization coverage survey. The program staff collected their data from Well Baby Clinics records.

a. Last Year's Accomplishments

Immunization coverage rates have gradually decreased alarmingly in the passed five years. ASIP have been working diligently in a collaborative effort with other agencies including MCH, DOE, WIC and community health centers to combat this problem.

A new development towards this Performance Measure was the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human and Social Services) and was previously located at one central location. In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency had agreed to

collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will improve immunization coverage by improving accessibility of Well Baby Clinic services to the WIC clients.

The MCH Program continued to collaborate with the American Samoa Immunization Program (ASIP) and Nursing Services to maintain immunization coverage in the community by offering free Well Baby/Child services, offering health education and public awareness on the importance of immunizations for children, and provide follow-up of children who have missed their scheduled vaccinations. MCH also provided clinicians who conduct physical assessments of all children before receiving their vaccinations, and who are also on hand in case of any adverse events.

The MCH Program provided infrastructural support by providing and maintaining a database in each of the health centers that enables the nurses to look up individual records with ease, generates lists of children expected on any given date and a list of those who missed their appointments.

The CSHCN staff also worked collaboratively with the Immunization program and the Nursing services to ensure that all children with special needs receive age appropriate immunizations. This was facilitated through home visits, clinic visits and referrals from other agencies. The CSHCN staff made routine visits to the health centers to check clinic records for the immunization status of children in the program. When a child is found needing an immunization the CSHCN staff would transport the child and their family to the health center for the appropriate vaccinations. In cases where child could not come to the health center the nurse practitioner would administer the vaccinations at home.

A Hepatitis Nurse was also recruited by ASIP and is currently carrying out home visits; keeps track of all Hepatitis carriers at prenatal clinics and maternity ward; and ensures that they get their shots.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization and MCH programs collaborate on activities such as posting billboards, posters and pamphlets.		X		
2. Media coverage on the importance of childhood immunizations includes radio spots, TV shows and spots on the evening news.		X		
3. Vaccine Providers are also given Immunization updates and reminders regarding up to date immunizations for children.		X		
4. The Department of Health also partners with other agencies such as to refer children who are not update with their immunizations.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Like the MCH Program, one of the biggest challenges faced by the Immunization Program is staffing. Nurses are in very short supply, contributing to congestion at the Well Baby Clinics, and

the overall low coverage rates. The Immunization Program is currently hiring more staff to accommodate the increased work load. A School Nurse and an Outreach Nurse are expected to be hired by the beginning of FY 2011. Joint plans include implementing a joint school outreach team that will include both MCH and Immunization program staff. The efforts of the team will include providing immunization and preventive dental services to school children in a coordinated effort.

Other activities for this measure include community outreach activities; catch up clinics, mass media campaigns, and coordinating efforts with other agencies such as WIC, Head Start, and other interdisciplinary public and private sector organizations. ASIP had also applied for funding for a mobile health unit to facilitate outreach clinics in order to boost Immunization levels among families, and got funded under the ARRA project. With the assistance of the new Home Visiting Grant (ACA), it will enable a cost-sharing of the mobile van for the school team's means of transportation. There are future plans to recruit retired and off duty nurses who are willing to work after hours and weekends to conduct community outreach (catch up clinics) activities.

c. Plan for the Coming Year

The MCH staff will continue to coordinate services with the community health centers, nursing services, and the ASIP to maintain and boost the current immunization coverage level. One of the key strategies is to review ASIP policies and procedures to ensure vaccines are deployed accordingly as well as regular in-service training for new vaccine updates and schedules.

The MCH Health educator who visits the day care centers will also be reinforcing the importance of immunization coverage and providing necessary information to parents and providers. Referrals to the health centers will be made as appropriate to ensure adequate protection of young children from vaccine preventable diseases.

The following activities are part of the plan to address needs identified in the Needs Assessment :

- Incorporate into the WBC education module any developed public education materials for parents (contraindications & deferring appointments) from IP.
- Revise educational materials inserted into the prenatal educational modules prior to dissemination.
- Attach the immunization schedules in the Health Education Modules for Prenatal, to promote awareness prior to giving birth (third trimester).
- Update colorful posters (media campaign) with local pictures and catchy phrases to display at the WBCs.
- Assist ASIP to determine what barriers there are and if they are not already known to conduct focus groups or one on one surveys (interview face to face or by phone).
- Coordinate with ASIP to develop activities to address identified barriers through mass media campaign.
- IP will provide incentives for up to date well baby clients to promote consistent visits
- Assist ASIP in identifying Hep B carriers at the Maternity Ward and refer to the Hep B Nurse at the Immunization Program.
- Strengthen partnerships by continuing to enlist their assistance in identifying incomplete immunization cards through referrals.

- Continue Day Care outreach
- Annual Participation for Head Start (ECE) Registration
- Establish school team using a mobile van
- Continue providing community outreach for each district by CHC nurses after hours and at week-ends.
- Coordinate and implement the 2nd Immunization Health Role Model. All up-to-date clients will be entered in a raffle. Winners drawn from each district will get their photographs

displayed on existing billboards as part of the mass media campaign.

- Will assist the ASIP launch Immunization Week in April 2011-through vaccination campaign out in the community.
- The ASIP will be carrying out 8 Summer Outreach activities -after hour clinics to improve coverage rates by utilizing nurses in 8 different village sites (districts) after hours and on week-ends.
- ASIP plans to mobilize its nurses including the Hep B Nurse, School Nurse, and the Outreach Nurse; to the health centers as core personnel.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	21	20	11	10	14
Annual Indicator	11.7	11.0	14.8	15.6	18.9
Numerator	22	33	27	29	29
Denominator	1883	2990	1828	1856	1535
Data Source				Vital Statistics	Labor and Delivery Logbook and Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	18	17	16	15	14

a. Last Year's Accomplishments

The MCH Program continues to play an active role on the Teen Pregnancy Prevention Coalition each year. The coalition is a collaborative effort between the Department of Health, AS Medical Center Authority, and other community agencies to prevent teen pregnancies. The coalition works with church, youth and community groups to promote awareness about teen pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH staff will collaborate with the Teen Pregnancy Prevention coalition to promote abstinence education.		X		
2. The MCH Nurse Practitioner provides family planning services that also serve teens seeking education and contraception.		X		
3. The MCH Women's Health Nurse Practitioner has a weekly radio program that allows callers to ask questions on various topics including teen reproductive health and abstinence.		X		
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program provides free health education, counseling and reproductive health services to the community in the four health centers and the American Samoa Medical Center Authority. These services are offered to teens and their families during regular working hours and expanded clinic hours in the evenings.

The MCH program is one of the major partners for the Gear Up Program, a cohort college preparatory program for adolescents. 2009 is the third year of this partnership that has followed a cohort of teens from 7th to 9th grade, and will continue until this cohort graduates high school. The MCH staff has been addressing adolescent health issues with this group of teens, their families and teachers. This year reproductive health was introduced as one of the topics to the teens. The education activities emphasized knowing their bodies, how to care for and respect their bodies, and how to protect themselves against pregnancy and sexually transmitted diseases.

c. Plan for the Coming Year

The MCH Program will continue to develop an adolescent health curriculum including teen pregnancy/sexual activity (reproductive health). Once curriculum is established, focus groups will be facilitated to ensure adequacy and literacy. The MCH Program had the opportunity to continue providing outreach activities at the Gear Up Summer Camp, and will plan more activities for the next coming school year. With the expansion of school health services to include a School Health Nurse (Immunization Program) and an Outreach Nurse, there will be more opportunities to address these issues with teens. Again, one of the issues teens identified was difficulty talking to their parents about issues such as teen pregnancy or anything related to sex. They find it easier to seek their friends for advice. The MCH staff acknowledges these difficulties and will be working with teens, parents and community members to overcome this barrier. This is a very sensitive issue; therefore strategies to address it in a culturally sensitive manner that is developed collaboratively with both teens and their parents, are being developed by MCH staff and key stakeholders.

The MCH program continues to partner with the Teenage Pregnancy Prevention Coalition (TPPC) to address the rising rate of teenage pregnancy in the territory. They will be meeting quarterly to identify needs and gaps as well as coordinate and implement outreach activities. These activities will be carried out during Parents and Teachers conferences, church group meetings and other community functions. TPPC specifically targets parents and caregivers, who are encouraged to discuss these issues at home with their children, promoting abstinence coupled with reproductive health and RESPONSIBILITY.

This curriculum will also be incorporated into the Education Modules at the WCCs for teens that are coming back for booster shots and HPV vaccines. Related posters will be developed and disseminate to all partners and stake holders. Evaluation of all health education materials will be facilitated by the Community Cancer Coalition and the Community Cancer Network.

The MCH staff will also work to develop video PSA's on adolescent health issues.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	35	25	32	45	45
Annual Indicator	4.2	41.9	44.1	60.7	43.0
Numerator	72	609	631	639	459
Denominator	1699	1455	1430	1053	1067
Data Source				MCH School Outreach Data	MCH School Outreach
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	45	47	50	52	55

a. Last Year's Accomplishments

A total number of 459 students (85%) had at least one permanent molar sealed. A total number of 540 third grade students out of 1067 enrollees were screened in the school year 2008-2009. Despite the team's hard work and drive to provide a maximum amount of third graders screened annually, this resulted in an overall annual indicator of 43.0 (Table I). In May 2009, a Sealant Evaluation was conducted and reported 65.5% sealant retention. Each member of the outreach team, including dental assistants, had been placing these sealants. Awareness and improved sealant technique application led to this improvement. The dental team which consists of a collaborative partnership between MCH and SCHIP staff were able to carry-out dental services at 22 public schools (95.6%) and 2 private schools. MCH concentrated on providing third grade students while SCHIP provided services to second and fifth grade students.

Every child was given a dental report card to let parents and/or caregiver know about their dental status. It also informs them of any need to take their child for further treatment and why. Those who were complaining of toothaches at the time of screening were treated immediately at school (either by simple dental extractions and/or dental restorations) or referred to the nearest dental clinic (root canal treatments and more complicated dental extractions that may need dental x-rays). A total number of 375 (69.44%) students had at least one tooth affected by dental caries.

It was unfortunate that Dr. Siasau and dental assistant Serafina Roe left the program on June 2009 to work at the dental clinic in Tafuna Community Health Center. This left only Dr. Uso as the remaining MCH Dentist.

Other outreach activities were:

- i) Day Care Centers: Attended Day Care Centers' Health Awareness Activities, raising dental health awareness among children who were attending Day Care Centers in American Samoa. A total number of 310 children and their families attended this three day celebration
- ii) Children's Dental Health Month: In the month of February 2009, the dental team had visited twelve schools, promoting dental health to celebrate Children's Dental Health Month. Students were screened, received fluoride varnish application and report cards to take home. Each

participant received a toothbrush, dental floss, and a sticker as incentives. The total number participating in the dental month celebration was 551 children all together, as shown in Table V.

iii) Department of Education Health Fair: Dr. Siasau and Serafina Roe carried out dental screenings for children of all age group during the Department of Education's Health Fair. A total number of 317 were seen by Dr. Siasau.

iv) Gear Up Summer Camp: The Dental Team had planned to join the MCH staff, and incorporate a Healthy Body - Healthy Mind campaign at the Gear Up Summer Camp, June 2009.

v) Training to improve service capacity: In March 2009, the MCH dental team attended the Community Based Primary Oral Health Care Training, organized by the Tafuna Family Health Center. Others that joined this training included MCH health educators, CSN Family nurse practitioner -- Mrs. Tele Hill, MCH and Well Baby Clinic physicians, Tafuna Health Center Dental clinic staff, and LBJ Dental staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH Dentists work with the Department of Education to provide preventive dental services to school children on site free of charge.	X			
2. The MCH Dental team will revise the consent form to make it easier for parents to give consent for services at the schools.				X
3. The MCH multimedia campaign will include public service announcements on fissure sealants and nutrition to promote oral health.		X		
4. The MCH Dental School Team will send out weekly reminders in the media to alert parents which schools the team is visiting to ensure a maximum number of third graders are seen.		X		
5. The MCH Dental team has developed educational pamphlets and materials that will be distributed at community outreach activities.		X		
6. The MCH Dental team provides free preventive dental services for children during Children's Dental Health Month as an annual promotional activity.	X			
7. The MCH dental team will be conducting screening of fourth graders for fissure sealant retention.	X			
8.				
9.				
10.				

b. Current Activities

The MCH program is currently focusing on recruitment and hiring of new staff before the beginning of the new school year. This remains a challenge as all of the dentists on island are currently already employed by the AS Medical Center Authority, as an authority the hospital offers a higher pay scale than does the Department of Health making it difficult to recruit to fill the current vacancies. The MCH program is exploring recruiting from the neighboring islands to fill these positions.

Dr. Uso was fortunate to have three volunteers from the Ameri-Corps Office assist her in this year's efforts to improve dental health among the children population. MCH is currently working

on hiring additional staff to replace Dr. Siasau and Serafina Roe plus one more dental assistant. Dr. Uso continued to provide dental preventive services to third grade and second grade students.

A total number of 3 elementary schools had requested dental health talks and was provided in February 2010. The MCH staff has been receiving Needs Assessment Training MCH Consultant Dr. Henry Ichiho. By March 2010 he had visited American Samoa three times and trained MCH staff on:

- i. Quantitative and Qualitative Data collection
- ii. Data analysis

Dental supplies have been inventoried regularly and the MCH coordinator has been reordering those which are in need of resupplying.

c. Plan for the Coming Year

Dr. Anaise Uso will continue to screen and provide preventive dental services to all third grade children and Children with Special Care Needs in Elementary Schools. She will also be joining the Immunization staff to form a School Health team. It is anticipated that combining staff and other resources will enable both programs to provide more comprehensive services. The following are activities planned for the coming year:

- Establish policies and procedures Manual for the MCH Dental outreach program. This will be systematic and comprehensive, identifying types of services expected to provide and grades (2nd & 3rd) to be covered.
- Consent forms will be revised and readjusted to include notification that each will consent to 2 years of dental services. This is to cover re-screening after a year for sealant retention and reapplication if they are partially intact or absent.
- Establish school schedule with LBJ team and submit to DOE, as well as CSN and other collaborating partners (Immunization, CFIDD, SPED)
- Generate regular outreach reports at the end of each school and turn in to the MCH Coordinator.
- Establish sealant retention survey at the beginning of every school visit to determine those who need to be resealed.
- Establish regular inventory of dental supplies to determine items in short supply and submit to the MCH Coordinator for reordering, 3 months in advance.
- MCH will continue to recruit and hiring of 1 dentist and 2 dental assistants.
- Coordinate with DOE and all partners to implement 2011 Wellness Fair
- Coordinate with Day Care Centers to provide annual dental visits

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	4	4	3
Annual Indicator	0.0	4.4	3.8	0.0	4.5
Numerator	0	1	1	0	1
Denominator	23487	22720	26444	25783	22212
Data Source				Vital Statistics	Death Data from HISO-ASHA

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	1	1	1	1	1

a. Last Year's Accomplishments

Only 1 death was reported due to motor vehicle deaths in 2009. This performance measure is impacted by the very low speed limit of 25 miles per hour in the Territory, as well as enforcement of the limits. The Territory has seen an increase in the number of vehicles on the road and speeding has been hindered with added congestion on the roadways.

Vehicle safety has been included as one of the safety topics in the Well Baby Clinic education modules and is reinforced by the health education staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH health education staff will partner with the Department of Public Safety and EMSC to include vehicle safety in existing health education activities.				X
2. The MCH health education and Nutrition staff will continue partnership with Daycare centers to provide proper vehicle safety education to the Daycare Centers.		X		
3. Motor vehicle safety is a topic covered by the health education modules of the Well Baby Clinic.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues to promote vehicular safety through education at the community health centers, the day care centers and through the media. The MCH Program is also partnering with the Office of Highway Safety to strengthen data capacity for this measure, focusing on reporting measures in place for highway accidents that will shape intervention efforts. Two MCH health educators have received training from Office of Highway Safety and got certified to inspect and install infants and children's car and boosters seats.

c. Plan for the Coming Year

The MCH staff will continue to partner with the Office of Highway Safety and the EMSC program to promote child safety and vehicular safety in the community. In a partnership with the Office of Highway safety, the MCH Program will continue data collection activities to the community health

centers and village dispensaries as well as increase public awareness on the "Anchor, Tether Latch campaign" for the child restraint promotion program. The Office of Highway safety will provide technical assistance to MCH staff in order to provide education to parents on appropriate use of car/booster seats. This will also include training of more MCH staff and its partners to become licensed technicians as car seats inspectors and installers. Through this partnership, families will be able to attain car seats for no cost while ensuring parents participate in a vehicular safety education program. This project will be incorporated into routine prenatal and well baby/child clinic services.

MCH staff plans that policies and procedures for recruiting clients for car seat installation will be established. Recruitment sites will include Well Baby Clinics, Prenatal clinics and the Maternity ward. Once clients are recruited a plan will be establish for an appointment system in which clients are required to show up with their car seats at various seat inspection and installation stations/sites in order for technicians from MCH, as well as partners from Social Services and EMSC program, for inspection (own car/booster seats) and installation.

Clients recruited from the WBC and prenatal clinics will be established and appointed to each installation sites.

All activities will be documented and reported on a regular basis to MCH Coordinator and the Department of Public Safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		35	36	36	37
Annual Indicator	35.4	34.2		45.0	19.4
Numerator	585	675		605	42
Denominator	1652	1973		1345	216
Data Source				Well Baby clinic Data	Leone & Amouli Well Baby Clinic Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	37	38	39	40	43

Notes - 2009

Data reported for this measure is a sample survey of mothers who access services at the Leone (western district) and Amouli (eastern district) clinics but does not include the two larger clinics in the central areas.

Notes - 2007

The data reported for this measure in 2007 reflects data collected from the two largest Well Baby Clinics. Data has not been collected from the two smaller clinics at the time of this report. This data will be corrected once it has been analyzed.

a. Last Year's Accomplishments

The data reported for last year is only for the health centers in Leone and Amouli. There have been problems with collecting and documenting of Well Baby Clinic Data for Tafuna and the Central clinic. WIC representative at the Needs Assessment training mentioned that they have a higher number than 37% but did not provide an accurate report at this time.

The MCH Program continued efforts in order to lay a solid foundation of education and information on breastfeeding during the prenatal period in order to help mothers choose exclusive breastfeeding as a feeding method. The MCH Program continued to make breastfeeding a priority area in its health education efforts at the community level as well.

The MCH Staff incorporated breastfeeding education within 24 hours after delivery. The rooming-in policy allows new mothers to have full access to their newborns, and breastfeeding counseling is provided on the first day of the postpartum stay in the hospital. Free breast pumps are also available at WIC, and for mothers with premature or sick babies at the nursery to utilize in expressing breast milk for their infant.

The MCH staff continue breastfeeding education and counseling to women accessing prenatal care in all of the community health centers as well as the OBGYN clinic. One on one counseling is also conducted at the Maternity Ward post delivery. The MCH staff are on hand to provide support and coaching for mothers who need help with breastfeeding initiation. The MCH hotline telephone number is also given out for mothers to call if they need additional support at home. Breastfeeding is one of the nutritional topics covered in education and counseling at the well baby clinics for mothers who are bringing in their infants or toddlers in for a Well Baby Clinic visit.

Breastfeeding radio spots air continuously on the local radio stations throughout the year. The MCH staff also broadcast television shows on breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education on breastfeeding to women attending prenatal clinics in the community health centers and the American Samoa Medical Center Authority OBGYN clinic.		X		
2. Continue to air public service announcements on the benefits of breastfeeding and colostrum on local radio stations.		X		
3. Continue to broadcast TV shows on breastfeeding on the Department of Health sponsored TV show "O Lou Soifua Maloloina" or Here's to Your Health.		X		
4. Continue to provide breastfeeding coaching and counseling to postpartum mothers at the Maternity Ward at American Samoa Medical Center Authority.		X		
5. Continue to provide education and breastfeeding tips to mothers attending Well Baby Clinic at the community health centers.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff continues breastfeeding education and counseling to women accessing prenatal care in all prenatal clinics, as well as WIC, at all WIC offices. MCH Staff continues to provide one-on-one counseling at the Maternity Ward post delivery, and who are also receiving phone call checks 2 days later, to ensure that clients are satisfied or need further assistance. The MCH hotline telephone number is also given out for mothers to call if they need additional support at home. Breastfeeding continues to be one of the nutritional topics covered in education and counseling at the well baby clinics for mothers who are bringing in their infants or toddlers in for a Well Baby Clinic visit.

Breastfeeding radio spots are aired continuously on the local radio stations throughout the year. The MCH staff also broadcast television shows on breastfeeding.

c. Plan for the Coming Year

1. Continue breastfeeding education at prenatal, well baby clinics and the maternity ward.
2. Continue outreach sessions to promote breastfeeding during the Prenatal Period by coordinating with the Mulumugaveve coordinator, Leuga Turner, to provide at least 6 community outreach sessions in FY 2011. The first session will be implemented by October 2010.
3. Continue multimedia campaign on the importance of breastfeeding such as providing at least 2 TV talk shows and/or Radio talk shows.
4. Continue calling mothers to follow up on breastfeeding in 2 days after Discharge from hospital.
5. Celebrate World breastfeeding Week (August 1-7) by hosting TV program discussions, radio announcements and developing handouts (card) tips for dissemination at Maternity Ward and WBCs.
6. Revise the Well Baby Module 2009 (Research 0-5yrs old) by updating Flip Chart, Posters, Brochure and other educational materials.
7. Conduct two Breastfeeding Focus Groups (3RD Trimester - Working Mothers and Not working Mothers) to ascertain their knowledge and practices around breastfeeding which will assist the approaches and activities used to promote this issue.
8. Establish a breastfeeding committee (Women Group) who are volunteers willing to be trained to become breastfeeding mentors in their communities.
9. Develop a Breastfeeding Work plan (Executive Order 2000) -- to coordinate and establish the Breastfeeding Policy to accommodate ASG employees to increase numbers of breastfeeding mothers. This group can also be solicited to provide feedback and be involved in the development of a breastfeeding plan.
10. Develop a Breastfeeding Booklet (2011) for all health care providers to utilize.
11. Collect data and document. Monthly reports will be provided to the MCH Coordinator.
12. Continue to partner with the WIC Program: The WIC Staff's workplan includes the following:
 - a. Increase food vouchers for moms who are excl. bf to buy fruit & veggies.
 - b. Education and counseling for moms
 - c. NO formula for combination feeding moms for the 1st months, encouraging moms to excel in breastfeeding.

d. Breastfeeding coalition group that is sustainable

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	0	0	30
Annual Indicator	0.0	0.0	0.0	0.0	91.2
Numerator	0	0	0	0	1241
Denominator	1720	1442	1291	1338	1361
Data Source				No Data source	Part C & HISO-ASHA
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	91	92	92	93	93

Notes - 2009

This data was reported by Part C, Helping Hands Early Intervention. Their program staff carries out newborn hearing screening at the LBJ Medical Center's nursery room prior to discharge.

Notes - 2008

AS does not have a hearing screening program.

a. Last Year's Accomplishments

In 2009 the Department of Health was awarded a newborn screening grant and began screening in the beginning of the year. Currently the early intervention staff is providing the screening and follow-up as this new project also provides technical support by a team of audiologists from off island. There were 1361 live births and 1241 (91.1%) were screened for hearing (birth admission screens) using OAE. Of those who were screened, 941 passed the screening and 269 failed. Newborns who failed the assessment were referred to contracted audiologists to reassess. Only 3 received diagnostic evaluations. One had no hearing loss, one required monitoring for suspected hearing loss and is scheduled for a follow-up, and the third found with a hearing loss and moved off-island so was never enrolled in EI.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen newborns for hearing before hospital discharge.			X	
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Due to contracting problems, the audiologists who provided diagnostic evaluations were unable to return. Thus referrals were sent to the ENT clinic at the American Samoa Medical Authority. The Helping Hands Program is currently working on recruiting audiologists for referrals. The MCH Program continues to partner with the early intervention Helping Hands program to provide services to infants and their families. The CSHCN staff routinely work with the Helping Hands staff to follow up children with special health care needs.

c. Plan for the Coming Year

The MCH Program will continue to partner with the early intervention Helping Hands program to provide services to infants and their families. The CSHCN staff routinely work with the Helping Hands staff to follow up children with special health care needs, and will continue to do so in 2011.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	0	0	0
Annual Indicator	NaN	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	0	22720	26444	26863	26863
Data Source				Census Estimates	Census Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	0	0	0	0	0

Notes - 2009

This measure is not applicable for American Samoa. The American Samoa law states that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for healthcare are the administrative fees charged at the hospital.

Notes - 2008

This measure is not applicable for American Samoa. The American Samoa law states that all residents including children receive free medical services at the government hospital and Public

Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for health care are the administrative fees charged at the hospital.

Notes - 2007

This measure is not applicable for American Samoa. The American Samoa law states that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for health care are the administrative fees charged at the hospital.

a. Last Year's Accomplishments

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This measure does not apply to American Samoa.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

c. Plan for the Coming Year

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed

eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		50	50	14	14
Annual Indicator	0.0	0.0	14.0	14.3	33.6
Numerator	0	0	1230	1053	1421
Denominator	2031	3341	8791	7358	4225
Data Source				Well Baby database	WIC Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	33	33	32	32	31

Notes - 2009

This data was reported by American Samoa's WIC Program.

Notes - 2008

This data was generated from the Well Baby Clinic records.

Notes - 2007

The data reported for this measure is of the children served at the Well Baby Clinics as WIC is unable to extract this data from the current WIC database.

a. Last Year's Accomplishments

The MCH Program is currently reporting this data from the Well Baby Clinics, of those children who participate in WIC. MCH staff provides individual nutrition counseling with the parents or caregivers at the Well Baby Clinics. These sessions includes:

- Breastfeeding benefits (for mother and infant)
- Infant feeding: Infant food preparation for children 6mos to 1 year old.
- Young child feeding: Healthy local diets for children 1 year old to 5years old.
- 24 hour diet recall

The MCH Staff utilizes the "SOAP (subjective objective assessment planning)" method in the client's folders to ensure follow-up in clients care. This method basically covers the development of a care plan specifically for nutrition that is done collaboratively with parents/care givers. The plan is documented and can be followed up by any of the Well Baby Clinic staff in order to track each child's progress.

In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will strengthen capacity to address this measure by coordinating nutrition education efforts as well as increasing accessibility of Well Baby Clinic services to the WIC clients.

As education and public awareness are the larger parts of this performance measure, the MCH program plans to conduct an assessment of the methods of education and communication used for childhood nutrition. This is to find out what families are learning from the current communication methods, confirm which methods are most effective for our population and also to find out who primary and secondary audiences for this information really is. Those who are responsible for feeding and meal preparation for the children need to be targeted, and they may not be the parents or those who are currently being targeted.

There is a need for the MCH and nursing staff to receive in-service trainings and updates on child BMI, growth and development. The MCH coordinator will ensure that this will be made possible in 2010, to strengthen skills and competencies among service providers. This will begin with Public Health staff, and hopefully expand to other service providers such as those in day cares. Another activity will be to review and revise the Well Baby Clinic education modules to address this issue, and staff in-service on the correct usage of the modules.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide nutrition education and counseling to families at Well Baby/Child clinics.		X		
2. The MCH staff will work closely with the new Nutritionist hired recently by the Department of Health to promote healthy eating and local foods in the community.				X
3. Provide tip cards to parents with iron rich local foods and snacks to help boost dietary iron intake among children.		X		
4. In partnership with the child care agency the MCH staff will provide nutrition education to all day care providers on Tutuila and Aunuu.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program continues to offer nutrition education and counseling for children at the well baby clinics, at the day cares and through public service announcements. Posters and pamphlets have been distributed and posted to all health centers and other public places to increase awareness about healthy nutrition.

Continuing education on child BMI, growth and development is a continuing need for MCH and for nursing staff as well. Training and continuing education will be provided on these topics in 2010, to strengthen skills and competencies among service providers for children. This will begin with Public Health staff first, and hopefully expanded to other service providers such as day

cares. The Well Baby Clinic education modules are currently being reviewed to address this issue.

c. Plan for the Coming Year

1. Continue breastfeeding education for pregnant women, mothers of infants and young children. Continue reinforcing to caregivers about healthy balance diet, healthy portions, regular exercises and reducing screen time using Brist Futures Best Practice guidelines, and adapting recommendations from the "Lets Move!" campaign. Design and print out pamphlets, posters, and/or magnets for dissemination.

2. Head Start ECE will continue to provide nutrition assessments when the child registers, and with work with School Lunch Program to review menu for children. MCH will also coordinate with ECE to provide Physical Activity promotions for teachers, caregivers and kids and continue to assist them in their plans.

3. Collaborate with WIC, Land Grant and Health Centers to promote growing and buying local foods during Health Promotion Activities (e.g. Nutrition Month, Wellness Fair, Health Center Wk etc.)

4. Contact DOE & School Lunch Program to allow MCH educators to present on various topics to teachers and staff during Teacher's Orientation Week prior to commencement of next school year, 2010-2011.

5. Formulate policies and procedures for all the above activities.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		20	20	10	7
Annual Indicator	0.0	2.1	3.3	2.5	2.5
Numerator	0	30	10	8	8
Denominator	1720	1442	300	314	314
Data Source				PRAMS-like survey	PRAMS-like survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	5	3	2	1	1

Notes - 2009

No data is available at this time. This data was usually collected from the pregnancy risk assessment survey. But there was no PRAMS-like survey for 2009.

a. Last Year's Accomplishments

The MCH Program did not implement an adequate pregnancy risk assessment survey in 2009. MCH staff continued to address the dangers and effects of smoking on both mother and baby at prenatal clinics. The MCH health educator is a certified cessation facilitator and is trained to provide cessation support for any women who need or request cessation classes.

The Tobacco Control Program also support this measure through education and awareness activities. This includes a weekly radio program on the dangers of tobacco, that enables listeners to call in and ask questions. There is also a Smoking Quitline that provides support for anyone interested in quitting or smoking cessation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH Health Education and Nutrition program staff will partner with the Tobacco Control Program to provide education and awareness activities on the dangers of tobacco use to prenatal mothers.		X		
2. Tobacco use prevention will also be included in the media campaign currently airing on the radio and public television station to target mothers and their families.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff provides education on risk behaviors during pregnancy to all prenatal women. Women who do report they are smoking during pregnancy can be referred to the Tobacco Program (Cessation Program and Quit Line) for additional services.

Department of HHealth's Substance Abuse program provides health education to pregnant mothers whom are clients at the WIC program. This is twice a month to enforce prevention of alcohol and drug abuse including cigarette smoking during pregnancy. There is a plan to train MCH staff on screenings of potential clients and referring to them for counseling.

c. Plan for the Coming Year

The MCH Program will continue to address smoking during pregnancy in the prenatal, post partum, and Well Baby clinics and in public service announcements. The MCH Program will also continue to work closely with the Comprehensive Cancer Control Program and the Community Cancer Coalition to reintroduce a Clean Air bill into the local legislature to provide and enforce smoke free environments for all.

The MCH educators will plan to Promote Smoking Quit Line (WBC Module) Tobacco & CCC - refer to quit line, radio program on KSBS weekly, Smoke Free Environment Act, develop policies and procedures and education plan for SFEA for vendors. Work with CCC and CCN to develop locally developed health education materials, include pretesting and piloting.

Other activities include:

- a) A plan to Conduct the next Prams survey 2011.
- b) Creat 1 translated Samoan flyer about the effect of smoking during pregnancy.
- c) Carry out 8 community outreach sessions for 2 women's church group.
- d) Update knowledge on prenatal care, including the effects of smoking during pregnancy.
Education during clinics, PNC & WBC
- e) Document and report all findings in a regular basis to the MCH Coordinator and all partners.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	41	40	40	39	15
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	5223	5430	5320	6317	5223
Data Source				Vital Statistics	Vital Statistics & 2000 Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	0	0	0	0	0

Notes - 2009

There have been no data reported on this performance measure from Vital statistics.

Notes - 2008

There were no events reported for this measure.

Notes - 2007

There were no events reported for this measure.

a. Last Year's Accomplishments

The MCH Program continues efforts to coordinate with other programs and agencies that provide counseling and other services related to teen suicide. Of late, there has been a decline in the incidence of teen suicide in American Samoa. This may be attributed to the increase in teen/youth involvement programs, from church activities, sports activities, and the recent development of a strategic prevention coalition in the community to prevent substance abuse,

and an active child abuse prevention coalition.

The MCH program is an active partner in many of these organizations and activities. The MCH staff participates in teen coalitions and community outreach activities geared towards youth/teens. Teen suicides have been at a decline and therefore more pressing issues such as reproductive health, substance abuse, and obesity have taken more of the focus of efforts in adolescent health.

MCH continues to partner with Gear Up, a cohort college preparatory program for adolescents. 2009 is the third year of this partnership that has followed a cohort of teens from 7th to 9th grade, and will continue until this cohort graduates high school. The MCH staff has been addressing adolescent health issues with this group of teens, their families and teachers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH staff will partner with the Teen Suicide Prevention coalition to provide services and connect with teens.				X
2. The MCH staff will partner with other agencies and programs which provide services to teens to promote self esteem, and address issues surrounding teen suicide.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues to partner with Gear Up, a cohort college preparatory program for adolescents. One of the topics discussed with these teens is knowing the signs of suicidal tendencies and being brave enough to talk to someone you trust.

Teen Suicide will be addressed in the new school year with the Gear Up students, teachers and parents. Teen suicide will be addressed as a component of the overall adolescent health curriculum to be used in 2011. The MCH Program will also continue to partner with other community organizations to address this and other teen health issues.

c. Plan for the Coming Year

Teen Suicide will be addressed in the new school year with the Gear Up students, teachers and parents. Teen suicide will be addressed as a component of the overall adolescent health curriculum to be used in 2011. The MCH Program will also continue to partner with other community organizations to address this and other teen health issues.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
---------------------------------------	------	------	------	------	------

Annual Performance Objective	0	0	0	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1720	1442	1291	1338	1361
Data Source				Vital statistics	HISO-ASHA
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	0	0	0	0	0

Notes - 2009

American Samoa does not have a high risk birthing facility.

Notes - 2008

AS does not have a high risk birthing facility.

Notes - 2007

AS does not have a facility for high risk deliveries.

a. Last Year's Accomplishments

American Samoa does not have facilities for high-risk deliveries and neonates. All high risk deliveries are handled by the American Samoa Medical Center Authority.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. . This Measure does not apply to American Samoa.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

American Samoa does not have facilities for high-risk deliveries and neonates. All high risk deliveries are handled by the American Samoa Medical Center Authority.

c. Plan for the Coming Year

American Samoa does not have facilities for high-risk deliveries and neonates. All high risk deliveries are handled by the American Samoa Medical Center Authority.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	13	13	14	14	19
Annual Indicator	14.7	15.0	22.1	19.5	23.1
Numerator	73	82	96	225	155
Denominator	496	547	435	1153	670
Data Source				MCH Database	MCH Kotelchuck Index Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	22	22	21	21	20

Notes - 2009

American Samoa does not use the US Standard Birth Certificate, therefore the data reported for this measure is collected manually by MCH staff from prenatal and maternity records.

Notes - 2008

American Samoa does not use the US Standard Birth Certificate, therefore the data reported for this measure is collected manually by MCH staff from prenatal and maternity records.

Notes - 2007

This is preliminary data collected thus far. It is a sampling of the prenatal records. This is only provisional and will be updated in the progress report in December 2008.

a. Last Year's Accomplishments

Activities related to this measure include a financial incentive program implemented by the American Samoa Medical Center Authority (ASMCA). The financial package or sliding fee rewards women who access care in the first trimester, by offering a package deal that covers the costs of prenatal visits and one night in-patient post partum admission. For non-resident women, the entire prenatal, delivery and post-partum package is a flat rate of \$500 for normal delivery (not including high risk or cesarean deliveries), and for residents the entire package is free provided prenatal clinic participation is consistent and starts in the first trimester.

The MCH program maintained a media campaign on radio and TV to air public service announcements promoting prenatal care and the prenatal incentive package. The incentive package is also available to women who access care at the community health centers, as long as they also meet all of the participation/eligibility criteria.

Free prenatal services are available at two Public Health clinics, in addition to the services offered at the ASMCA.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free prenatal care at the Tafuna Family Health Center, Amouli Health Center and after normal clinic hours at the Tafuna Family Health Center and the American Samoa Medical Center Authority OBGYN clinic.	X			
2. Offer incentives for women who access prenatal care in the first trimester of pregnancy.		X		
3. Provide education and community awareness of the newly implemented financial incentive package for early initiation of prenatal care at the LBJ Medical center.		X		
4. Implement a pregnancy risk assessment survey that is PRAMS-like to determine the leading barriers for accessing prenatal care and ways to improve prenatal services for all women.				X
5. Continue a multimedia campaign airing public service announcements on the benefits and importance of continuous prenatal care beginning in the first trimester.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program continues to provide free prenatal services, promotion of free services available and of the incentive package offered by the hospital for women who access care in the first trimester.

A new development towards this Performance Measure is the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human and Social Services) and was previously located at one central location. In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will improve participation in prenatal clinics by improving accessibility of WIC services to the women who access prenatal clinics.

c. Plan for the Coming Year

Although efforts to improve prenatal care have shown some increase in early participation, the local rates are far below the Healthy People objective and national rates. It is apparent that new approaches must be employed to improve this measure. Better data collection and analysis is a top priority, to identify the subgroups of women who are least likely to access services in order to target specific interventions. The effectiveness of health communications in this area must also be evaluated, to ensure the right message is reaching the right audience. Plans to do this include focus groups, and key informant interviews to assess current outreach and education methods. This information will be used to revise or develop new strategies in health communications, as well as to revise the health education modules used for prenatal clinics.

After the initial analysis of the PRAMS-like survey conducted in AS, it was discovered that many

women who were becoming pregnant did not intend to become pregnant (at the time or at all), nor did they access any family planning service. MCH plans include a closer investigation into this information, in order to address the issue of pregnancy intendedness and family support issues. MCH staff will work closely with the OBGYN and Family Planning programs at the ASMCA and women in the community to develop and implement strategies to address this issue in a culturally sensitive manner.

Other activities planned by the Prenatal Group after the Needs Assessment were:

1. Set up an appointment system to Prenatal clinics (PNC).
2. Continue Health education at prenatal clinics.
3. Continue outreach program.
4. Continue multimedia campaign.
5. The MCH health educator will promote 3 PNC Sliding Scale Payment Packages. (LBJ)
6. Continue after hours PNC services.
7. The MCH health educators will plan to collect and report data-Report back to: Jackie
8. The MCH health educators will plan to Revise PNC Educational Module.
9. The MCH Program will plan to Provide MCH --Prenatal vitamin and iron pills.
10. The PNC staff will improve accessibility to clinics.
11. The MCH staff will improve waiting time, customer service to clinics.

D. State Performance Measures

State Performance Measure 1: *Percent of infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10	11	12	13
Annual Indicator	14.7	15.0	22.1	18.2	40.7
Numerator	73	82	96	210	273
Denominator	496	547	435	1151	670
Data Source				MCH data system	Postpartum and Infant data cards
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	15	15	15	18	

Notes - 2008

The data reported for this measure is collected by the MCH staff, but does not include 100% of live births. The denominator is the total number of records collected by MCH staff. As AS does not use the US Standard birth certificate, prenatal history data is not readily available but must be collected manually.

Notes - 2007

This data was collected from a random sample of prenatal records. Thus is provisional.

a. Last Year's Accomplishments

The MCH program continues to provide Prenatal care services free of charge in the Tafuna Family Health Center which serves the second largest number of pregnant women in the Territory. MCH staff also provides prenatal services in the remotest part of Tutuila at the Amouli

health center located on the eastern tip of Tutuila.

Activities related to this measure include a financial incentive program implemented by the American Samoa Medical Center Authority (ASMCA). The financial package or sliding fee rewards women who access care in the first trimester, by offering a package deal that covers the costs of prenatal visits and one night in-patient post partum admission. For non-resident women, the entire prenatal, delivery and post-partum package is a flat rate of \$500 for normal delivery (not including high risk or cesarean deliveries), and for residents the entire package is free provided prenatal clinic participation is consistent and starts in the first trimester.

The MCH program maintained a media campaign on radio and TV to air public service announcements promoting prenatal care and the prenatal incentive package. The incentive package is also available to women who access care at the community health centers, as long as they also meet all of the participation/eligibility criteria.

Compared to last year's fiscal year, numbers for fiscal year 08 -- 09 increased. Efforts of the MCH Educator and the Nutrition Educators met the regular goal in attending the three prenatal clinics on island. The prenatal care health messages are derived from the prenatal modules which are utilized by the Health Educators to deliver messages. These modules include step by step prenatal health topics for each gestational week. These modules also include prenatal care education which is part of the health presentation conducted at the Well Baby Clinics.

- Individual Health Educators have not quite completed incorporating health materials for printing and translation due to other activities to attend to and the length of time to prepare materials for piloting in the community using the communication behavior change technique.
- The goal to carry out community outreach sessions for women's at two church groups were somewhat met. Ideally a church setting was the community setting we planned on, although due to other activities promoting women's health the health message was delivered at these events e.g. The American Samoa Cancer Coalition's launching of a radio program out reach.
- The purchase request for prenatal incentives was not met due to infrastructural organization.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free prenatal care at the Tafuna Family Health Center, Amouli Health Center and after normal clinic hours at the Tafuna Family Health Center.	X			
2. Continue a multimedia campaign airing public service announcements on the benefits and importance of continuous prenatal care beginning in the first trimester.			X	
3. Provide education and community awareness of the financial incentive package for early initiation of prenatal care at the LBJ Medical center.		X		
4. Implementing a pregnancy risk assessment survey that is PRAMS-like to determine the leading barriers for accessing prenatal care and ways to improve prenatal services for all women.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH continues to offer Prenatal services in three locations free of charge to participants. Prenatal services are also offered after normal working hours free of cost for women who cannot attend the clinic during regular hours. Incentives are provided to women who access prenatal care in the first trimester. An ongoing media campaign promotes early and continuous prenatal care for healthy moms and healthy babies. This includes radio spots, a live call in radio show twice a week and TV shows that promote prenatal care.

Current health activities includes health education and promotion at the Prenatal and Well Baby clinics:

- Conducting behavior change, health education material focus groups and questionnaires.
- Creating a radio spot promoting the prenatal financial package.
- Airing a television program promoting early prenatal care.
- Partnering with other Governmental and Non Governmental organization's for community outreach health promotion.

c. Plan for the Coming Year

Although efforts to improve prenatal care have shown some increase in early participation, the local rates are far below the Healthy People objective and national rates. It is apparent that new approaches must be employed to improve this measure. Better data collection and analysis is a top priority, to identify the subgroups of women who are least likely to access services in order to target specific interventions. The effectiveness of health communications in this area must also be evaluated, to ensure the right message is reaching the right audience. Plans to do this include focus groups, and key informant interviews to assess current outreach and education methods. This information will be used to revise or develop new strategies in health communications, as well as to revise the health education modules used for prenatal clinics.

After the initial analysis of the PRAMS-like survey conducted in AS, it was discovered that many women who were becoming pregnant did not intend to become pregnant (at the time or at all), nor did they access any family planning service. MCH plans include a closer investigation into this information, in order to address the issue of pregnancy intendedness and family support issues. MCH staff will work closely with the OBGYN and Family Planning programs at the ASMCA and women in the community to develop and implement strategies to address this issue in a culturally sensitive manner.

The PNC Staff will plan to set up an appointment system to PNC -- place reminder calls and follow up calls for missed appointments.

Other activities are:

- The MCH health educators will plan to continue health education at prenatal clinics.
- The PNC Staff will plan to set up a referral system to PNC.
- The MCH health educators will plan to Continue outreach program.
- The MCH health educators will plan to Continue multimedia campaign.
- The MCH health educators will plan to promote 3 PNC Sliding Scale Payment Packages. (LBJ)
- The PNC Staff will plan to continue after hours PNC service.
- The MCH health educators will plan to collect and report data-Report back to:

- The MCH health educators will plan to Revise PNC Educational Module.
- The MCH Program will plan to Provide MCH --Prenatal vitamin and iron pills.

State Performance Measure 2: *Percentage of annual re-evaluation of Children with Special Health Care Needs (CSHCN) by the Interdisciplinary Team.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		98	50	60	90
Annual Indicator	97.9	76.4	87.9	91.9	100.0
Numerator	143	107	123	125	146
Denominator	146	140	140	136	146
Data Source				CSHCN data	CSHCN data
Is the Data Provisional or Final?				Provisional	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	91	92	93	95	

a. Last Year's Accomplishments

The CSHCN team has been able to provide home-visitations to 100% of its clientele.

About 60% were SPED students seen annually for physical assessments within the classroom or at the CSHCN examine room. Consent forms were signed before a client was given a thorough assessment by the MCH Pediatrician and nurse. Further health care needs were discussed with parents who were present for this purpose or with an attending SPED teacher in the absence of the caregiver/parent.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide evaluations for children with special health care needs in the home setting to maximize interaction with the family.	X			
2. Continue to provide annual evaluations for children attending Special Education at the center and the other outlying schools.	X			
3. Continue to attend grand rounds at the Pediatric Ward of the LBJ Medical Center to identify children early and ensure services are provided according to their needs.				X
4. Continue to partner with other agencies and service providers to coordinate services for children and their families.		X		
5. Continue to work with community health centers to track and follow-up children with special health care needs and to ensure all children receive age appropriate immunizations in a timely manner.				
6.				
7.				
8.				
9.				

10.				
-----	--	--	--	--

b. Current Activities

The CSHCN staff continues to partner with families and service agencies to ensure comprehensive and timely delivery of necessary services for CSHCN. The activities to address this measure are centered on collaborative methods to reach children where they are. This will include the CSHCN team joining the MCH Dental Outreach team in their visits to the schools so that CSHCN receive both dental and medical services in a manner that is less disruptive than physically coming to the Public Health clinics/offices.

The CSHCN team collaborates services with Helping Hands Early Intervention program for children with special health care needs from birth to 3 years, the pediatric team at LBJ Medical Center and the non-profit organization CFIDD to coordinate necessary, appropriate, and continuous medical care in the home as needed. Parents are informed of procedures, proper care and handling of child in the home. Caregivers are also given the opportunity to ask questions or share concerns regarding the care of child.

c. Plan for the Coming Year

Plans for the coming year include recruitment of both a nurse and an occupational therapist for the CSHCN team. Both positions have been extremely difficult to fill. Despite advertising both positions there have not been any individuals seriously interested from American Samoa or abroad. The MCH program will work with other partners to plan and implement new recruitment strategies for the coming year.

Continue to partner with the Dental team, Immunization, Part C (Helping Hands) and others to provide annual assessments to all CSHCN clients.

State Performance Measure 3: *Percent of 2, 3, and 4 year old children who are seen in the in the MCH Well Child Clinics who access dental health services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		12	14	16	18
Annual Indicator	35.3	10.8	14.9	31.4	9.7
Numerator	1067	362	563	1532	28
Denominator	3020	3341	3791	4875	289
Data Source				MCH Data system	Leone and Amouli Well Baby Clinics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	20	22	22	23	

a. Last Year's Accomplishments

The data for 2009 is data reported by Well Baby Clinics. These are children who received fluoride varnish application and dental assessments by health practitioners. They also refer clients to the dental clinic within the health centers if needed. This data was usually obtained from the Head Start program but it was not available at this time. The MCH school outreach team partners with

the SCHIP dentist to provide Head start clients dental health care, both preventive and curative. Because it is mandatory for Head Start children to receive dental screenings and treatments, 100% of these children access their dental health services at Head Start.

There were difficulties implementing this measure at the Well Baby Clinics. Although the MCH providers can refer children to the dental clinic at the same dispensary/health center, there is only one dentist at the largest health center (Tafuna Health Center) and he is unable to handle both acute care patients and well clients. The dental clinics at the other health centers are staffed by ASMCA dentists who charge a fee for all patient visits, which is a barrier for most patients. Despite referrals to the dental clinics, most Well Baby clients either cannot be seen by the dentist, or prefer not to pay a fee for a dental visit unless there is an acute problem.

The MCH dental team was able to provide dental preventive services to 57 children in this age-group during February 2009, promoting Children's Dental Health. The team took one day each week and stationed their dental chair at each Well Child Clinic, providing dental screening, fluoride varnish application, toothbrushing demonstration, as well as giving out toothbrushes, toothpastes and floss.

Despite efforts to assist in improving oral health among the children population, there is still a need for better documentation and reporting.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with the dental staff at the community health centers to develop referral system for Well Baby clinics.				X
2. Provide protocols and supplies for all Well Baby/Child clinicians for application of fluoride varnish.				X
3. Establish a mechanism to collect data on all referrals and 2 - 4 children seen.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently one of the MCH Well Baby providers are providing fluoride varnish as part of the routine visits. Other activities have been suspended due to lack of MCH dental staff, until the remaining MCH dentist returns from Maternity leave and the vacant dental positions are filled.

In 2009 the MCH program in conjunction with the Tafuna Family Health Center co-sponsored a dental assistant training program. All of the MCH and SCHIP dental staff and the Well Baby clinicians participated in this training, to train the dental assistants as well as update the dentists with current techniques, procedures and recommendations in children's preventive dental care. This training helped increase the capacity for local dental staff to be trained in Public Health dentistry, which had not happened prior to this training.

c. Plan for the Coming Year

The MCH dental team will work closely with the dental clinics at each of the community health centers to establish a better referral system for MCH well child visits. As one of the MCH dentists is now working at the busiest health center, efforts will be made to work closely with him to develop a referral system for both the Well Baby Clinics and the school outreach team. Similar efforts will be made with the other health centers as soon as they open the dental clinics there. Children will be seen as early as 6 months old and be given fluoride application as well as an oral hygiene package by the health care providers at the Well Baby clinics.

State Performance Measure 4: *Percentage of 4 month olds in Well Baby Clinics who are exclusively breastfed.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		25	25	30	31
Annual Indicator	31.2	27.1	31.2	54.6	16.9
Numerator	516	416	353	605	40
Denominator	1652	1534	1132	1109	237
Data Source				MCH data system	Leone and Amouli Well BAby Clinics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	31	32	32	33	

a. Last Year's Accomplishments

In FY 2009, the MCH Program continued efforts in order to lay a solid foundation of education and information on breastfeeding during the prenatal period in order to help mothers choose exclusive breastfeeding as a feeding method. The MCH Program continued to make breastfeeding a priority area in its health education efforts at the community level as well.

The MCH Staff incorporated breastfeeding education within 24 hours after delivery. The rooming-in policy allows new mothers to have full access to their newborns, and breastfeeding counseling is provided on the first day of the postpartum stay in the hospital. Free breast pumps are also available at WIC, and for mothers with premature or sick babies at the nursery to utilize in expressing breast milk for their infant.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education on breastfeeding to women attending prenatal clinics in the community health centers and the American Samoa Medical Center Authority OBGYN clinic.		X		
2. Continue to air public service announcements on the benefits of breastfeeding and colostrum on local radio stations.		X		
3. Continue to provide breastfeeding coaching and counseling to postpartum mothers at the Maternity Ward at American Samoa		X		

Medical Center Authority.				
4. Continue to provide education and breastfeeding tips to mothers attending Well Baby Clinic at the community health centers.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff continue breastfeeding education and counseling to women accessing prenatal care in all of the community health centers as well as the OBGYN clinic. One on one counseling is also conducted at the Maternity Ward post delivery. The MCH staff are on hand to provide support and coaching for mothers who need help with breastfeeding initiation. The MCH hotline telephone number is also given out for mothers to call if they need additional support at home. Breastfeeding is one of the nutritional topics covered in education and counseling at the well baby clinics for mothers who are bringing in their infants or toddlers in for a Well Baby Clinic visit.

Breastfeeding radio spots air continuously on the local radio stations throughout the year. The MCH staff also broadcast television shows on breastfeeding.

c. Plan for the Coming Year

The MCH staff plan to conduct focus groups, and some informal information gathering discussions with women in their last trimester or within 6 months of delivery in order to ascertain their knowledge and practices around breastfeeding. Although breastfeeding is continuously promoted through education and mass media, the secondary audiences for this information have not been identified. Most of the information has been traditionally focused on the mothers, however those who are involved in the decision making process need to be included as well. With this information, the approaches and activities used to promote breastfeeding can be fine tuned and more focused.

The MCH staff plan to develop or adopt a framework breastfeeding plan for prenatal and post-partum mothers to be used as a guide to help reinforce their plans for breastfeeding. Similar to a birthing plan, the idea is to help women prepare for breastfeeding prior to delivery to ensure greater success. The plan will include helpful tips and educational material, from positioning and nipple care to including fathers and other family members in the feeding plan. Often mothers are not prepared for the demands and challenges of breastfeeding and often are not able to overcome barriers. The breastfeeding plan will help women anticipate challenges and decide with her partner and family how to address those challenges, with guidance and assistance provided by MCH staff both prenatally and postpartum. The guide will also contain contact information and resources where they can find help.

Finally, the MCH Program plans to develop a breastfeeding support network of women in the community, church groups who are interested and willing to be breastfeeding mentors in their communities. One of the barriers to breastfeeding women have identified is the lack of support at home. To address this need the MCH program plans to develop partnerships with women in the community who can provide breastfeeding support in the homes. The MCH staff will provide training, coordination, and technical support and follow up for the mentors. This will be a pilot project in 2011, and begin with 3 church groups. This group can also be solicited to provide feedback and be involved in the development of a breastfeeding plan.

State Performance Measure 5: *Percent of 14-17 year olds attending school who admitted to smoking in the last 30 days.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		40	39	24	24
Annual Indicator	0.0	40.0	24.2	24.2	24.2
Numerator	0	614	878	878	878
Denominator	1535	1535	3625	3625	3625
Data Source				YRBS data	2007 YRBS data
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	22	22	20	20	

Notes - 2007

The numerator reported for this measure is the total number of survey participants in the 2007 YRBS, which had greater success in response rate than in previous years.

a. Last Year's Accomplishments

The data for this performance measure is derived from the YRBS data from the Department of Education for 2007. The data for the 2009 YRBS have not yet been released.

The MCH program works closely with the Health Curriculum section of the Department of Education, Gear Up, the Comprehensive Cancer Control Program, and Taitaitama Project (substance abuse prevention) to coordinate outreach activities for teens. These activities center on teen risk behaviors such as obesity and tobacco use.

The Department of Health is currently working to re-introduce a Clean Air bill into the local legislature to prevent environmental tobacco smoke. The local task force on selling tobacco to minors has also been active in enforcing the tobacco selling laws at local stores and vendors. Currently, new public service announcements on tobacco use among youth are being developed and piloted with teens from the local community and was launched later in 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH staff will partner with the Tobacco Control Program to provide education and awareness activities on the dangers of tobacco use to elementary school children.		X		
2. A Clean Air bill will be introduced to the legislature to prevent exposure to second hand smoke.		X		
3. TATU training – teen mentoring against tobacco use training of trainers planned for 2010.		X		
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

The MCH staff work in collaboration with the Gear Up program to address adolescent health issues with students, teachers and parents. Another partner in this collaboration is the substance abuse prevention coalition. A key focus of this partnership is to ensure academic success of students by offering health and social supports such as skills to avoid risk behaviors. MCH will continue to work with Gear Up to address adolescent health issues such as tobacco use.

c. Plan for the Coming Year

The MCH Program will continue to partner with the Comprehensive Cancer Control Program and Community Cancer Coalition, and the Substance Abuse Prevention project to implement TATU -- Teens Against Tobacco Use. This model is a teen mentoring program aimed at using teens as facilitators in tobacco use prevention classes. It is anticipated that a training of trainers can be organized for the later part of 2009, where teens will be invited to participate. Trainers will be recruited from the Gear Up students, the substance abuse prevention community coalitions and the community to participate in this project.

State Performance Measure 6: *To decrease the percentage of 1 year olds with low hemoglobin (less than 11)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		54	29	29	28
Annual Indicator	30.0	31.0	10.9	27.2	62.6
Numerator	517	484	157	339	144
Denominator	1726	1562	1440	1245	230
Data Source				MCH data system	Tafuna and Leone WBC
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	28	27	27	26	

Notes - 2007

In 2007 there was equipment failure with the hemoglobin testing units. For this reason the data reported for this year reflects a much smaller number of children screened. The program has since ordered new machines and this data is expected to be a better reflection of hemoglobin testing in 2009.

a. Last Year's Accomplishments

The MCH Program is currently reporting this data from the Well Baby Clinics, of those children who participate in WIC. MCH staff provide individual nutrition counseling with the parents or caregivers at the Well Baby Clinics. These sessions includes:

- Breastfeeding benefits (for mother and infant)
- Infant feeding: > Infant food preparation for children 6mos to 1 year old.
- Young child feeding: > Healthy local diets for children 1 year old to 5years old.
- 24 hour diet recall

The MCH Staff utilizes the "SOAP (subjective objective assessment planning)" method in the client's folders to ensure follow-up in clients care. This method basically covers the development of a care plan specifically for nutrition, that is done collaboratively with parents/care givers. The plan is documented and can be followed up by any of the Well Baby Clinic staff in order to track each child's progress.

In addition, group teachings are done in all Well Baby Clinics. The total number of children who received nutrition education at the Well Baby Clinics in 2009 was 1499. On March 2010, the MCH Program celebrated National Nutrition Month. For this month the MCH Program had a number of promotional activities to promote children's nutrition. The MCH Program organized a poster and recipe competition for elementary schools. Both government and private schools participated. The event was advertised on the TV, newspaper and radio. As a result, 156 children participated during these activities.

Radio spots continued to air on promotion of infant and young child feeding with a number to call if there are any questions. TV programs continue to air discussing the importance of nutrition.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide nutrition education and awareness to families at Well Baby/Child clinics.	X			
2. Provide hemoglobin screening for infants and 1 year olds at the Well Baby Clinic along with nutrition education.	X			
3. Provide iron supplements to families with children who have low hemoglobin levels free of charge.		X		
4. Provide multivitamin supplements to children free of charge with nutrition counseling and education.		X		
5. In partnership with the child care agency the MCH staff will provide nutrition education to all day care providers on Tutuila and Aunuu.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program offers nutrition education and counseling for children at the well baby clinics, at the day cares and through public service announcements. Posters and pamphlets have been distributed and posted to all health centers and other public places to increase awareness about healthy nutrition. These materials have been adapted to feature local foods, both good and bad and have also been translated. The nutritional value of local fruits and vegetables has been incorporated into health education sessions for children and families.

A new development towards this Performance Measure is the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human and Social Services) and was previously located at one central location. In 20210, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will strengthen capacity to address this

measure by coordinating nutrition education efforts as well as increasing accessibility of Well Baby Clinic services to the WIC clients.

c. Plan for the Coming Year

As education and public awareness are the larger parts of this performance measure, the MCH program plans to conduct an assessment of the methods of education and communication used for childhood nutrition. This is to find out what families are learning from the current communication methods, confirm which methods are most effective for our population and also to find out who primary and secondary audiences for this information really is. Those who are responsible for feeding and meal preparation for the children need to be targeted, and they may not be the parents or those who are currently being targeted.

Continuing education on child BMI, growth and development is a continuing need for MCH and for nursing staff as well. Training and continuing education will be provided on these topics in 2011, to strengthen skills and competencies among service providers for children. This will begin with Public Health staff first, and hopefully expanded to other service providers such as day cares. A third activity will be to review and revise the Well Baby Clinic education modules to address this issue, and staff in-service on the correct usage of the modules.

Recommendations for nutrition intervention in this age group include iron supplementation, deworming, exclusive breastfeeding, and use of fortified foods. In the past the MCH program has made efforts to provide iron supplements for children served at Well Baby Clinics with iron deficiency, however there is an expensive practice and cannot be sustained with current resources. Supplementation will be continued in 2010 but only a limited supply can be furnished for those families in greatest need. Other families will have to purchase the iron supplements. Fortified foods are readily available, and are included in the WIC food package which a majority of children have access to. Deworming is being implemented as part of the lymphatic filariasis elimination campaign, however the medication is not recommended for children below 2 years of age. Deworming will have to be prescribed by a clinician. Breastfeeding has been a MCH priority for the last 10 years, and will continue to be in 2011.

State Performance Measure 7: *Percent of children among the children with special needs who are known to the CSN Program who receive an annual dental assessment.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective			60	62	64
Annual Indicator	20.5	57.9	87.9	93.4	64.4
Numerator	30	81	123	127	94
Denominator	146	140	140	136	146
Data Source				MCH School Outreach data	MCH School Outreach
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	66	68	68	69	

a. Last Year's Accomplishments

Children with Special Health Care Needs (CSHCN) received better dental access last year compared to previous years. The annual performance measure targeted for year 2009 was 64%. The actual data shown in the table above is provisional and not yet finalized. This number include

all kids seen at Elementary schools that were in the Special Education Program (SPED), ECE SPED, those whom were seen during home visits together with the CSN nurse practitioner, as well as those whom were present at the Matafao SPED office during a three day dental screening in the month of October (2008) to promote Disability Month. All children were referred to the nearest dental clinic (dental home) for further dental treatment if needed. Every child seen gets a fluoride varnish application, given a toothbrush and toothpaste, with oral hygiene instructions reinforced using tooth-brushing demonstrations with models and puppets to both the child and parents/caregivers if present.

During the disability month on October 2009, the dental team provided dental screening, oral hygiene reinforcements, plus dental referrals (to the nearest dental clinic for treatments if needed) for children with Special Health Care Needs. This was a partnership between the MCH programs and the CFIDD, Center for Families of Individuals with Developmental Disabilities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN and dental team will partner to ensure children with special health care needs who are attending school are seen by the school dental team.	X			
2. The CSHCN and dental teams will provide dental assessments to children with special health care needs in the homes.	X			
3. Children with special health care needs will be seen in the community health center nearest to them for dental treatments.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSN students are continued to be seen in school settings (Elementary), during home visits and at the CSN office (Samoana High School). Children receive both a physical and dental screening. During dental screenings, they are given fluoride varnish application, toothbrushing demo to both children and caregivers, and a report card that informs caregivers the dental status of their child and to see a dentist at the nearest dental clinic if dental treatments are needed.

c. Plan for the Coming Year

Since the past year's success rate of the CSN population seen by the dental team was due to the consistent coverage of CSN children in the elementary schools, this will continue in the new school year. Schedules will be consistently reviewed so that the CSN nurse practitioner, Mrs. Tele Hill, will be able available to provide physical screenings as well.

E. Health Status Indicators

Introduction

The MCH Program will continue to develop the systems for data capturing and reporting that enable monitoring of the Health Status Indicators. These efforts are combined with support from the States Systems Development Initiative, as well as key partnerships with ASMCA, the community health centers and other service agencies.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	3.8	2.8	3.3	1.6	0.7
Numerator	65	41	42	21	10
Denominator	1720	1442	1291	1338	1361
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Narrative:

The indicators addressing low birth weight are addressed through the services to prenatal women such as free prenatal clinics for clinical management, health education, nutrition counseling and the referral system. These efforts also include infrastructure building activities such as partnering with the ASMCA ObGyn service to monitor and assess issues with pregnancy and delivery, and developing strategies to address them.

Tobacco control activities are coordinated with the Comprehensive Cancer Control Program while referrals are made to the Tobacco Quit Line. One of the MCH educators is certified to provide cessation counseling for any MCH client who require this service.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	3.0	2.6	3.0	1.5	0.1
Numerator	51	37	38	20	2
Denominator	1689	1424	1271	1320	1349
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Narrative:

/2011/

Two members of the MCH Staff nutrition staff participated in the BodyWorks training course and are now certified trainers for this curriculum. The implementation of BodyWorks training of trainers increases capacity for the MCH Program and all other Department of Health Programs who participated in this training. Several members of the Department of Health staff were also trained as trainers in BodyWorks establishing a cadre of trainers to implement this service.

The MCH have included BodyWorks as planned activity to address nutrition, physical activity and obesity prevention for pregnant women and families accessing MCH services in the coming fiscal year.

//2011//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.3	0.6	0.5	0.4	0.1
Numerator	5	8	7	6	1
Denominator	1720	1442	1291	1338	1361
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Narrative:

/2011/

MCH prenatal services are coordinated closely with the clinical supervision of the ASMCA ObGyn Department. Any clients who are high risk are referred immediately to the ASMCA ObGyn clinic for closer supervision and clinical management. Low birth weight is historically not prevalent in this population.

//2011//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.3	0.6	0.6	0.5	0.1
Numerator	5	8	7	6	1
Denominator	1689	1424	1271	1320	1349
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Final
-----------------------------------	--	--	--	-------------	-------

Narrative:

/2011/

There was only one birth in this category reported in this reporting year. Efforts to increase access to prenatal care by providing financial incentives/subsidized care, and de-centralizing prenatal services may be attributed to this improvement. This indicator will be monitored to assure this was a true decline or if data reporting was also a factor.

//2011//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.0	4.4	3.8	3.9	0.0
Numerator	1	1	1	1	0
Denominator	24852	22720	26444	25783	22212
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2011/

Deaths and injuries in this category are few in American Samoa. Enforcement of traffic and safety laws are attributed to this low rate. The speed limit is 25 miles per hour, and high speed accidents are rare.

//2011//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	4.4	3.8	0.0	4.5
Numerator	0	1	1	0	1
Denominator	24852	22720	26444	25783	22212
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2011/

The MCH Coordinator is a member of the Highway Safety Traffic Records Coordinating Committee in an effort to create data linkages for motor vehicle data. The MCH staff will continue to partner with the Office of Highway Safety and the EMSC program to promote child safety and vehicular safety in the community. In a partnership with the Office of Highway safety, the MCH Program will continue data collection activities to the community health centers and village dispensaries as well as increase public awareness on the "Anchor, Tether Latch campaign" for the child restraint promotion program. The Office of Highway safety will provide technical assistance to MCH staff in order to provide education to parents on appropriate use of car/booster seats. This will also include training of more MCH staff and its partners to become licensed technicians as car seats inspectors and installers. Through this partnership, families will be able to attain car seats for no cost while ensuring parents participate in a vehicular safety education program. This project will be incorporated into routine prenatal and well baby/child clinic services.

//2011//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	28.4	27.6	0.0	8.5	20.0
Numerator	3	3	0	1	2
Denominator	10579	10870	11546	11772	9999
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2011/

Deaths and injuries in this category are few in American Samoa. Enforcement of traffic and safety laws are attributed to this low rate. The speed limit is 25 miles per hour, and high speed accidents are rare. Very few teens have their own vehicles, so not as many are on the roads unsupervised.

//2011//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	58.4	94.5	77.6	319.6
Numerator	0	13	25	20	71
Denominator	23179	22270	26444	25783	22212
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Narrative:

/2011/

Unintentional injuries are addressed at the Well Baby/Child Clinics through the educational modules. Safety for children is addressed as part of the modules. Additionally, the Emergency Medical Services for Children program target injury prevention in all program activities.

//2011//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	53.7	39.6	41.6	38.8	0.0
Numerator	11	9	11	10	0
Denominator	20486	22720	26444	25783	22212
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

2011/

Deaths and injuries in this category are few in American Samoa. Enforcement of traffic and safety laws are attributed to this low rate. The speed limit is 25 miles per hour, and high speed accidents are rare.

//2011//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	51.6	36.8	129.9	101.9	0.0
Numerator	5	4	15	12	0
Denominator	9699	10870	11546	11772	9999
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2011/ There were no events reported for this measure. Efforts to promote roadway safety and enforcement have been well accepted in the community.

//2011//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.2	11.7	10.2	10.7	6.1
Numerator	1	35	30	32	15
Denominator	5611	2990	2946	2994	2476
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2011/

Chlamydia testing is done in the prenatal clinics by the MCH nurse practitioners. Case management and treatment services are also provided at no cost to patients. This situation will continue to be monitored in 2011. Education to teens and young people is also provided by MCH staff for Gear Up students and during community outreach activities.

//2011//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.1	4.1	4.4	7.0	0.0
Numerator	1	46	54	86	0
Denominator	11659	11260	12138	12348	10197
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2011/

Chlamydia testing is done in the prenatal clinics by the MCH nurse practitioners. Case management and treatment services are also provided at no cost to patients. This situation will continue to be monitored in 2011. Education to teens and young people is also provided by MCH

staff for Gear Up students and during community outreach activities.
 //2011//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1361	6	0	0	45	1310	0	0
Children 1 through 4	7370	0	0	0	0	7370	0	0
Children 5 through 9	9419	0	0	0	0	9419	0	0
Children 10 through 14	7987	0	0	0	0	7987	0	0
Children 15 through 19	6317	0	0	0	0	6317	0	0
Children 20 through 24	5413	0	0	0	0	5413	0	0
Children 0 through 24	37867	6	0	0	45	37816	0	0

Notes - 2011

Narrative:

//2011/

Better reporting on ethnicity data will be available pending release of new census data, as well better collection methods initiated at the various health services sites.

//2011//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1361	0	0
Children 1 through 4	7370	0	0
Children 5 through 9	9419	0	0
Children 10 through 14	7987	0	0
Children 15 through 19	6317	0	0
Children 20 through 24	5413	0	0
Children 0 through 24	37867	0	0

Notes - 2011

Narrative:

/2011/

Better reporting on ethnicity data will be available pending release of new census data, as well better collection methods initiated at the various health services sites.

//2011//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	0	0	0	0	0	0	0	0
Women 15 through 17	29	0	0	0	0	29	0	0
Women 18 through 19	194	0	0	0	0	194	0	0
Women 20 through 34	934	0	0	0	0	934	0	0
Women 35 or older	218	0	0	0	0	218	0	0
Women of all ages	1375	0	0	0	0	1375	0	0

Notes - 2011

Narrative:

/2011/

American Samoa is a very homogenous population. The majority are Pacific Islanders with some Asians, and few Caucasians.

//2011//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	0	0	0
Women 15 through 17	29	0	0
Women 18 through 19	194	0	0
Women 20 through 34	934	0	0
Women 35 or older	218	0	0
Women of all ages	1375	0	0

Notes - 2011

Narrative:

There were not Latino women reported.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	12	0	0	0	0	12	0	0
Children 1 through 4	12	0	0	0	0	12	0	0
Children 5 through 9	1	0	0	0	0	1	0	0
Children 10 through 14	1	0	0	0	0	1	0	0
Children 15 through 19	1	0	0	0	0	1	0	0
Children 20 through 24	1	0	0	0	0	1	0	0
Children 0 through 24	28	0	0	0	0	28	0	0

Notes - 2011

Narrative:

Causes of death by age were not reported for this indicator.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	12	0	0
Children 1 through 4	12	0	0
Children 5 through 9	1	0	0
Children 10 through 14	1	0	0
Children 15 through 19	1	0	0
Children 20 through 24	1	0	0
Children 0 through 24	28	0	0

Notes - 2011

Narrative:

No Latino deaths reported.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	32454	0	0	0	0	32454	0	0	2009
Percent in household headed by single parent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid		0	0	0	0	0	0	0	2009
Number enrolled in SCHIP		0	0	0	0	0	0	0	2009
Number living in foster home care		0	0	0	0	0	0	0	2009
Number enrolled in food stamp program		0	0	0	0	0	0	0	2009
Number enrolled in WIC	6000	0	0	0	0	6000	0	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009

Notes - 2011

Narrative:

Many of these services such as TANF are not available in AS. SCHIP and Medicaid data is also not applicable. Other data sources will be developed in the coming project year.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT	Total	Ethnicity Not	Specific
-----------------	------------------	--------------	----------------------	-----------------

Miscellaneous Data BY HISPANIC ETHNICITY	Hispanic or Latino	Hispanic or Latino	Reported	Reporting Year
All children 0 through 19	32454	0	0	2009
Percent in household headed by single parent	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	0.0	0.0	0.0	2009
Number enrolled in Medicaid	0	0	0	2009
Number enrolled in SCHIP	0	0	0	2009
Number living in foster home care	0	0	0	2009
Number enrolled in food stamp program	0	0	0	2009
Number enrolled in WIC	6000	0	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	2009

Notes - 2011

Narrative:

Data was only reported where available.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	1642
Living in rural areas	12045
Living in frontier areas	0
Total - all children 0 through 19	13687

Notes - 2011

Narrative:

These data will be updated upon release of current Census data.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	57291.0
Percent Below: 50% of poverty	28.0
100% of poverty	60.0
200% of poverty	87.0

Notes - 2011

Narrative:

87.7% of the population is at or below 200% of the poverty level. This is an estimate pending current data from the 2010 Census.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	57291.0
Percent Below: 50% of poverty	28.0
100% of poverty	60.0
200% of poverty	87.0

Notes - 2011

Narrative:

This data will also be made current upon release of the 2010 Census data.

F. Other Program Activities

Community Needs Assessment for Public Health Emergency Response to the Post-Earthquake and Tsunami on September 29, 2009: The Department of Health (DOH) conducted a community needs assessment to determine the various needs that DOH and its partners address these needs. It was conducted according to three major areas which were:

1. Basic public health needs with respect food, water, shelter, household goods, sanitation, public utilities, healthcare and infrastructure are accurately projected.
2. Special needs of the population are identified to include vulnerable populations, (i.e. children, the elderly, pregnant women, chronically ill, etc)
3. Special risk factors for further morbidity and mortality are identified, (i.e. use of carbon-monoxide generating equipment, access to clean drinking water, etc.)

With CDC's technical assistance, staff were trained prior to the implementation, documentation and reporting. The community health assessment in public health emergencies (CASPER) was used as the methodological approach, designed to rapidly determine the household-level needs of a disaster-affected community.

The various needs that were identified were:

- 1) Provide a continuing source of potable water, especially for persons dependent on relief agencies for water deliveries.
- 2) Provide immediate appropriate shelter for person with damage to their homes, including provision for temporary measures such as tarpaulins. Prioritize re-settlement in personal residences whenever possible. In cases where displacement is unavoidable, prioritize private residences and host communities over large shelters.
- 3) Provide a short-term feeding program for displaced populations that depend upon shelters for nutrition. Transition to sustainable food distribution as soon as possible during the recovery phase.
- 4) Provide accessible medical care for persons, particularly vulnerable populations such as nursing or pregnant women, the young, elderly and those with chronic health conditions. The current service of community-based clinics in and near affected areas in Leone and Amouli should be fully staffed. Consider community outreach of primary and preventive healthcare services in order to reach isolated populations and decompress the burden on clinics and the hospital.

- 5) Offer mental health services, including outreach services for persons unwilling to travel. Continue to coordinate local mental health services in conjunction with visiting teams.
- 6) Enhance the ability of public health surveillance systems to detect and monitor outbreaks of infectious diseases, including influenza, through ongoing collection and analysis of healthcare visit data.
- 7) Continue to monitor environmental health conditions, in association with the Environmental Protection Agency (EPA) during clean-up and recovery phases. Implement a waste management system for hazardous material disposal. Consider restricted burning in residential areas, to avoid toxic exposures and exacerbation of acute and chronic respiratory disease.
- 8) Engage environmental health authorities in planning and implementing a vector control program to reduce mosquito breeding sites and inform the public of measures to reduce the risk of mosquito bites.
- 9) Prevent illnesses from 2009 pandemic H1N1 influenza by implementing a community vaccination program.
- 10) Continue public education and risk communication through multiple media outlets. Provide guidance on self-protective behaviors to include food and water safety, hygiene messages, hazardous materials and carbon-monoxide exposures and environmental risks such as heat-related illness. Continue health education messaging related to self-protection and non-medical counter-measures for H1N1 at the personal, family and community levels. Continue mental health telephone help line services.
- 11) Promote worker safety during the cleanup and recovery phases to include falls, burns, electrocutions and equipment-related injuries, (i.e. chainsaws, gas stoves, generators, heavy equipment).

G. Technical Assistance

There is still a need for Data System Development territorial-wide. All partners should be able to enter this system and enter individual data pertaining to their program and services. In 2011, with the assistance of the SSTI grant, the TA contract from American Samoa Medical Authority will assist the department to set up the CPRS system in all health centers.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (Line1, Form 2)	516208	498448	538894		498448	
2. Unobligated Balance (Line2, Form 2)	0	0	0		0	
3. State Funds (Line3, Form 2)	387156	387156	404180		509523	
4. Local MCH Funds (Line4, Form 2)	0	0	0		0	
5. Other Funds (Line5, Form 2)	0	0	0		0	
6. Program Income (Line6, Form 2)	0	0	0		0	
7. Subtotal	903364	885604	943074		1007971	
8. Other Federal Funds (Line10, Form 2)	100000	100000	100000		100000	
9. Total (Line11, Form 2)	1003364	985604	1043074		1107971	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	135505	135505	138679		149534	
b. Infants < 1 year old	135504	135504	158679		152857	
c. Children 1 to 22 years old	271009	271009	297358		454947	
d. Children with	271010	253250	269402		149535	

Special Healthcare Needs						
e. Others	35000	35000	28956		51254	
f. Administration	55336	55336	50000		49844	
g. SUBTOTAL	903364	885604	943074		1007971	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	397480	397480	424383		503986	
II. Enabling Services	117438	117438	141461		151196	
III. Population-Based Services	225841	208081	226339		251992	
IV. Infrastructure Building Services	162605	162605	150891		100797	
V. Federal-State Title V Block Grant Partnership Total	903364	885604	943074		1007971	

A. Expenditures

Differences in amounts budgeted compared to amounts expended are due to a discrepancy in the amount forecasted for the budget that year. The amount of the working budget awarded at the beginning of the fiscal year was less the amount entered on the budget forms. Therefore the large difference in sums is due to a reporting error in the amount entered in the Budgeted column.

B. Budget

Maintenance of effort is maintained through State in kind match using local investments such as staffing in both administration and direct health services. Staffing to support MCH services include the health center staff: nurses, clerks, health assistants, doctors and other support staff. The Deputy Director of Health serves as the MCH Program Director. She and members of her staff in finance and personnel who provide administrative support are also included in State investment as her salaries are paid through State funding.

Local infrastructure is also a pivotal component of MCH services. All facilities where MCH

activities and services are delivered are government owned facilities. This includes the MCH and SSDI Office, and all of the clinics where MCH direct services are provided.

In the 2011 fiscal year, there is an increase in resources budgeted for direct health care services for pregnant women, infants, and children. The needs of these population for direct services has been increasing and the MCH Program make every effort to ensure services are accessible by offering them free of charge. With hard economic times, more and more families have come to depend on services offered by the Department of Health due to cost.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section "New State Performance Measure Detail Sheets and Data.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.